



NAVAL POSTGRADUATE SCHOOL

MONTEREY, CALIFORNIA

THESIS

**DRUG TREATMENT CENTERS IN AFGHANISTAN:
CREATING A PARTICIPATORY APPROACH TO
TACKLING THE DRUG TRADE**

by

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December 2012

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REPORT DOCUMENTATION PAGE			<i>Form Approved OMB No. 0704-0188</i>	
Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188) Washington, DC 20503.				
1. AGENCY USE ONLY (Leave blank)		2. REPORT DATE December 2012	3. REPORT TYPE AND DATES COVERED Master's Thesis	
4. TITLE AND SUBTITLE DRUG TREATMENT CENTERS IN AFGHANISTAN: CREATING A PARTICIPATORY APPROACH TO TACKLING THE DRUG TRADE			5. FUNDING NUMBERS	
6. AUTHOR(S) Angela K. Archambault				
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Naval Postgraduate School Monterey, CA 93943-5000			8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) N/A			10. SPONSORING/MONITORING AGENCY REPORT NUMBER	
11. SUPPLEMENTARY NOTES The views expressed in this thesis are those of the author and do not reflect the official policy or position of the Department of Defense or the U.S. Government. IRB Protocol number ____ N/A ____.				
12a. DISTRIBUTION / AVAILABILITY STATEMENT Approved for public release; distribution is unlimited			12b. DISTRIBUTION CODE A	
13. ABSTRACT (maximum 200 words) <p>This thesis assesses drug-treatment quality in the three Afghan provinces of Kabul, Kandahar, and Badakhshan by evaluating the extent to which UNODC and WHO standards of care are met. The assessment is structured to show how recovery capital, institutional development, and community action sway an addict's ability to quit drugs successfully. In contextualizing the case studies, a social-economic and political framework is also developed, finding a linkage between addiction, poverty, and drug trafficking. The most successful drug treatment programs follow the nine UNODC/WHO components, enrich community networks, invest in developing human capital, and adapt treatment protocols quickly to Afghanistan's unique circumstances. Provinces with vibrant markets are even more effective at providing quality drug treatment because they are more socially invested in their community. In conclusion, this thesis recommends that we consider the social implications—such as poverty, economics, mental health, and education—when tackling corruption and countering narcotics. Social programs cannot exist in a weak governance system that propels violence. Counseling addicts and improving poverty rates will improve trust between partnerships, instill a sense of empowerment within the poor, create an outlet for social change, and incentivize the community to move away from the illicit drug market.</p>				
14. SUBJECT TERMS Drug, Addiction, Afghanistan, Treatment, Socio-economic			15. NUMBER OF PAGES 121	
			16. PRICE CODE	
17. SECURITY CLASSIFICATION OF REPORT Unclassified	18. SECURITY CLASSIFICATION OF THIS PAGE Unclassified	19. SECURITY CLASSIFICATION OF ABSTRACT Unclassified	20. LIMITATION OF ABSTRACT UU	

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PARTICIPATORY APPROACH TO TACKLING THE DRUG TRADE**

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Submitted in partial fulfillment of the
requirements for the degree of

**MASTER OF ARTS IN SECURITY STUDIES
(STABILIZATION AND RECONSTRUCTION)**

from the

**NAVAL POSTGRADUATE SCHOOL
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ABSTRACT

This thesis assesses drug-treatment quality in the three Afghan provinces of Kabul, Kandahar, and Badakhshan by evaluating the extent to which UNODC and WHO standards of care are met. The assessment is structured to show how recovery capital, institutional development, and community action sway an addict's ability to quit drugs successfully. In contextualizing the case studies, a social-economic and political framework is also developed, finding a linkage between addiction, poverty, and drug trafficking. The most successful drug treatment programs follow the nine UNODC/WHO components, enrich community networks, invest in developing human capital, and adapt treatment protocols quickly to Afghanistan's unique circumstances. Provinces with vibrant markets are even more effective at providing quality drug treatment because they are more socially invested in their community. In conclusion, this thesis recommends that we consider the social implications—such as poverty, economics, mental health, and education—when tackling corruption and countering narcotics. Social programs cannot exist in a weak governance system that propels violence. Counseling addicts and improving poverty rates will improve trust between partnerships, instill a sense of empowerment within the poor, create an outlet for social change, and incentivize the community to move away from the illicit drug market.

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LIST OF ACRONYMS AND ABBREVIATIONS

AGF: Anti-Government Forces

AIDS: Acquired Immunodeficiency Syndrome

ANP: Afghan National Police

ART: Anti-Retroviral Treatment

BPHS: Basic Package of Health Services

CJTF: Criminal Justice Task Force

CNPA: Counter Narcotic Police of Afghanistan

CNL: Counter Narcotics Law

CPD: Central Prison Department

DAT: Drug Abuse Treatment

DDR: Disarmament, Demobilization, and Reintegration

DDR: Drug Demand Reduction

DRAT: Drug Demand and Reduction Action Team

EPHS: Essential Package of Hospital Services

GAO: Government Accountability Office

GIS: Geographic Information System

HIV: Human Immunodeficiency Virus

INL: The Bureau of International Narcotics and Law Enforcement Affairs

IDUs: Injection Drug Users

MCN: Ministry of Counter Narcotics

MOPH: Ministry of Public Health

NHA: National Health Account

NGO: Non-Governmental Organizations

OST: Opium Substitution Therapy

PTSD: Post Traumatic Stress Disorder

UNODC: United Nations Office on Drugs and Crime

USAID: U.S. Agency for International Development

WADAN: The Welfare Association for Development of Afghanistan

WHO: World Health Organization

ACKNOWLEDGMENTS

I would like to send my warmest thanks to those that assisted me throughout this research process. Deepest gratitude is due to Dr. Naazneen Barma, who was my main thesis advisor; she provided support, advice, guidance, and critically evaluated my thesis. I would additionally like to send my appreciations to my second reader, Dr. James Russell, and my academic advisor, Dr. Arturo Sotomayor for their support and dedication to my research. Without all of their wisdom and tireless assistance, this project would have been unsuccessful.

Next, I would like to give credit to the MOPH personnel and other interviewees for their willingness to work with me in ensuring the data was correct and thorough. Their contribution is what enriched my thesis and made it special.

Much acknowledgement should also go to my friends, family, and colleagues, especially to the following that were instrumental to the development of my thesis: Dr. Sandi Leavitt, Matt Dearing, Matt Dupee, Sara Kauffman, and Diana Beckett-Hile. These individuals supported me, provided inputs, and gave me reassurance when I was struggling. I cannot thank you all enough.

Finally, I would like to give a special shout out to my husband, Eric Archambault, for his inspiring and motivating conversations and his willingness to review my draft. Without his love and encouragement, this would have not been possible.

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I. INTRODUCTION

A. MAJOR RESEARCH QUESTION

This thesis explores a major element of the drug economy in Afghanistan, focusing on how individual addiction treatment efforts interact with the broader social and political context. According to the United Nations Office on Drugs and Crime (UNODC), “almost one million Afghans, roughly 8% of the population between 15 and 64 years old,” are addicted to opium, heroin, cannabis, or painkillers.¹ The percentage of Afghans that are drug dependent is above the global average (3.3% to 6.1%) and data suggests that it will continue to increase as violence spreads.² Most concerning is the use of opium; it is sold “extraordinarily pure here and very cheap—about \$3.50 for enough to get high,” because it is so abundant.³ UNODC reports propose that there is a linkage between drug trafficking, poverty, and addiction. In a sense, it is a vicious circle⁴; the impoverished in Afghanistan are more likely recruited to grow poppy or to transfer drugs illegally across borders, because they are more vulnerable. They become trapped when they are addicted and have to buy large quantities of opium to get their fix. Poor individuals will engage in risky behaviors, like the drug trade, if it means a chance at a better standard of living. Lower-income individuals additionally have more challenges to overcome, because they lack sufficient funding for counseling or medication, they are less informed about community resources, and are more likely to be depressed.⁵ These individuals then are stuck in the drug industry, because it is the only means to provide for their drug habit. Drug treatment programs that target basic needs of impoverished people

¹ UNODC, *Drug Use in Afghanistan: 2009 Survey* (United Kingdom: Foreign and Commonwealth Office, 2009), 1.

² Sandeep Chawla, *The World Drug Report 2011* (New York: United Nations Office of Drugs and Crime, 2011), 13.

³ Alissa Rubin, “Few Treatment Options for Afghans as Drug Use Rises,” *New York Times*, August 27, 2011, 1.

⁴ Thomas Schweich, *U.S. Counter Narcotics Strategy for Afghanistan* (U.S. State Department, 2007), 15.

⁵ Catherine Todd, “A Cross-Sectional Assessment of Utilization of Addiction Treatment among Injection Drug Users in Kabul, Afghanistan,” *Substance Use & Misuse* (2009): 416.

will reduce the demand for illegal substances in Afghanistan, which can in turn, decrease the desire and incentive to participate in the drug trade.

This thesis builds upon this argument that drug related violence and inequality stem from illicit transport. It does so, in particular, by examining the existing literature on the relationship between drug economies and civil conflict and insecurity in order to examine the potential for success in Afghan drug treatment programs. This latter literature typically places more attention on the socio-economic context surrounding individuals and assesses both drug producers and drug consumers to fully grasp how supply and demand can be suppressed without generating society-wide consequences.⁶ For example, where there are no jobs for individuals leaving the drug market, new businesses and community programs must be expanded to ensure alternative options are available. It is important to include socio-economic issues to fully comprehend the substance abuse dilemma and its impact on the future of Afghanistan's stability. These issues must be incorporated to guarantee the viability of drug treatment programs.

The core hypothesis of this thesis is that drug treatment centers linked to vibrant markets with legitimate economic opportunities make it more likely that an Afghan drug addict will recover without relapse. These markets will enrich community networks, and provide new employment alternatives. At the same time, socio-economic systems which are mostly organized by international and local aid agencies should be developed simultaneously with U.S.-led and UN-led counter-narcotic strategies to ensure treaties are enforced and Afghanistan is secure.⁷ In short, drug treatment programs have a small chance of being effective if they exist within a weak governance system that propels violence. In turn, the livelihood of the Afghan population is dependent on how the country provides economic opportunities for its poor as well as how it reduces addiction rates within its community. This type of development will be difficult if there is little incentive for the poor to move away from the drug market.

⁶ LaMond Tullis, *Handbook of Research on the Illicit Drug Traffic- Socioeconomic and Political Consequences* (Westport: Greenwood Press, 2011), 47.

⁷ Scott MacDonald and Bruce Zagaris. *International Handbook on Drug Control* (Westport: Greenwood Press, 1992), 430.

B. IMPORTANCE

Drug treatment should be prioritized in Afghanistan because it is interlinked with all the key variables that prevent the nation from becoming more stable: its insecure environment, its insurgent groups, and its role in drug production. There is a general consensus among Afghan experts that both the international community and the government of Afghanistan have failed to assist drug abusers and stop trafficking.⁸ The poor are being punished for their involvement with opium, even though it is their way of survival, while the Taliban and warlords are economically benefiting from the international community's strategies to diminish trafficking. In 2009, it was estimated that 53% percent of Afghans were living in poverty and 40% of them were unemployed.⁹ Poor individuals are more vulnerable to drug addiction, which, in turn, exacerbates their poverty and makes them reliant on a government that is unable to provide for them. For example, the typical drug user in Afghanistan is a married man with children; he is likely to be unemployed and/or uneducated and willing to "supplement his income, presumably to meet the cost of his drug use... by either selling his assets, borrowing money, stealing, begging, or committing other crimes."¹⁰ The large percentage of addicts, who prioritize highly potent and addictive drugs over basic living expenditures, has widened the national poverty gap and has perpetuated dependency on social welfare systems.¹¹

Addictions can cause unique challenges for a state social welfare system because widespread drug abuse often leads to an increase in poverty, mental and physical disabilities and criminal behavior. Welfare programs initiated by central government are unable to deliver resources (due to corruption and insecurity), which intensifies uncertainty that oftentimes leads to violence. According to Robert Watkins, "there are 40 drug treatment centers in Afghanistan, but treatment remains inaccessible to one-third of

⁸ Open Source Center, "Selection List: Afghanistan Press 27 Aug 11," last modified August 27, 2011, http://www.opensource.gov/portal/server.pt/gateway/PTARGS_0_0_200_203_121123_43/content/Display/SAP20110827950026

⁹ Todd, "A Cross-Sectional Assessment," 419.

¹⁰ UNODC, *Drug Use in Afghanistan: 2009 Survey*, 9.

¹¹ UNODC, "Drug Demand Reduction and HIV/AIDS," last modified 2011, <http://www.unodc.org/afghanistan/en/drug-demand-reduction-and-hiv-aids.html>

the country.”¹² Social services need to be enhanced so that Afghans can become more stable and economically self-sufficient. A more community-enhanced social welfare system would make the mental health, economic, and political/governance sector more credible. Having quality drug treatment programs in countries involved in the drug trade, would ensure individuals have resources to manage psychological scars from conflict. Enhancing education, unemployment, and addiction programs can be beneficial in fragile societies because it gives the impoverished more opportunities and lessens the discontent and animosity between social classes and ethnic groups.

An additional problem identified by Afghanistan health experts is concern over blood-borne diseases. Alarming, a recent study “found [Human Immunodeficiency Virus (HIV)] present in about 7 percent of drug users, double the figure just three years ago.”¹³ Even more concerning, Afghan children of all ages are struggling with substance abuse issues. It is common for mothers to give their child opium or painkillers as a means for comfort.¹⁴ This high rate of HIV patients and children addicts along with misuse of pharmaceuticals shows that there is a lack of educational awareness in regards to drug use. Preventative programs could reduce addiction rates and health outbreaks for the next generation, and are less costly for the central government to implement nationwide.

In short, drug trafficking is an international security concern because it undermines legitimate economic and social governance, which can in turn lead to distrust in government along with increasing economic and physical insecurity for individuals. This subsequently creates an optimal environment for insurgent groups to operate within. Many fear that drug profits will end up in the hands of terrorist groups who will attack principle consuming countries, such as the United States. The majority of Afghanistan’s drug-related problems lie in how its economic markets are structured: drug trafficking systems ensure that the majority of funds go to warlords and militias which attempt to weaken institutions, reduce economic diversification, widen the gap between rich and

12 CNN Wire Staff, “Report: Afghan drug addiction twice global average,” *CNN World News*. June 23, 2010, 1.

13 Rubin, “Few Treatment Options for Afghans as Drug Use Rises,” 1.

14 UNODC, *Drug Use in Afghanistan: 2009 Survey*, 3.

poor, and may perpetuate overall violence. Even though there are high risks associated with drug trafficking, the poor often chose to participate because the financial returns are so significant and, particularly in the absence of other economic alternatives, can ensure survival of family members.

Addiction in Afghanistan is heavily stigmatized by citizens and seen as a poor person's problem. Drug treatment, in conjunction with developmental programs, offers the best opportunities for Afghanistan's poor to overcome addiction and re-enter productive economic roles. Market development and new occupations which are not related to opium, should lead to a decrease in addiction. This research does not suggest that the international community should limit attention to governance and security; although both these components are crucial to rebuilding the country and to managing the global drug trade. Instead, this research recommends that we also consider the social implications—such as poverty, health, economics, and education—when creating programs to manage corruption and trafficking. Counseling addicts will help reduce the chance of continued conflict, instill a sense of empowerment within the poor, and create a framework for socio-economic change.

C. PROBLEMS AND HYPOTHESES

This thesis examines the role of drug treatment programs in Afghanistan and pinpoints services available to help potential and current drug users in three regions. Additionally, it assesses sustainability by evaluating how social and economic programs can be used as a tool to strengthen the community, so that addicts have a more stable environment to return to once finished with treatment. This research suggests that drug rehabilitation is not just an individual process but a societal one as well. To fully understand an addict's dilemma when quitting, environmental and social causal factors—such as having friends and family members who use drugs, managing physical cravings, getting income from drug market, and suffering from psychological trauma from war— will need to be addressed.

The core hypothesis is that treatment programs will be more effective when they emphasize awareness and prevention, understand cultural constraints, manage

environmental factors, and have extensive community resources. In addition, states or regions with stronger economic markets will have less difficulty with drug addiction, because there will be more welfare services available to help the poor. Regions that prioritize social programs will overtime have more advanced technologies, which should connect them to national organizations that will push for more cutting edge services and interventions. As a result, they will have more specialized staff because these drug treatment programs will be able to afford higher wages and offer an educational experience that new professionals will aspire to. The counter-hypothesis would suggest that economic markets have no impact on treatment centers and that success is dependent on the individual's motivation to quit. This alternative would then recommend more attention towards the effectiveness of counseling procedures rather than the community role in drug addiction programs.

Regions in Afghanistan that are more successful at treating addiction will have community awareness programs, training courses, an understanding of relapse triggers, less environmental challenges, and recovery capital. Recovery capital can be defined as, "the amount of personal and social resources an individual has available to provide strength and support in the process of recovery of addiction."¹⁵ Understanding relapse prevention methods is important because it unites local community networks in working together to ensure that addicts have resources once they leave rehabilitation facilities. In short, it is expected that drug treatment success will be determined not only by the quality of the drug treatment centers but by Afghanistan's ability to create mental health programs and vocational training as well as reduce corruption. Regardless of the clinic, addicts are likely to relapse if they return to a community which lacks welfare programs and sponsors to guide them back to a healthy lifestyle. The most effective treatment centers will network within the community and react quickly to environmental circumstances such as being near drug trafficking routes and/or managing victims who suffer from psychological symptoms of war.

¹⁵ Alexandre B. Laudet, "The Road to Recovery: Where are we going and how do we get there? Empirically-driven conclusions and future directions for service development and research," *Substance Use Misuse* 43, no. 12–13 (2008): 2012.

There is not much research available relating the effectiveness of drug treatment centers to such socio-economic variables. Mostly, political scientists and economists have focused on how illicit substances, such as opium, influence the international community via trafficking, arguing that eliminating drug trafficking, processing, and cultivation reduces corruption, improves governance, and allows for greater security.¹⁶ These strategies have improved Afghanistan's security and economic livelihoods for its population, but social welfare programs have not evolved to ensure continued effectiveness. This thesis demonstrates that welfare services, such as drug clinics, mental health counseling, and local economic reintegration employment programs will create more sustainable drug treatment success. Emphasizing economic livelihoods while improving poverty and mental health rates will allow Afghanistan to progress in its economic and political endeavors as well as potentially reduce the impact of its insurgent groups, which would prove to be beneficial for individuals, the government, and the international community.

D. METHODS AND SOURCES

To determine the effectiveness of drug treatment programs, the quality of individual/psychological interventions as well as structural/institutional capacity must be measured. The UNODC and the World Health Organization (WHO) have developed nine international components that they deem necessary when implementing community drug treatment programs worldwide. They are:

1. Availability and accessibility of drug dependence treatment
2. Screening, assessment, diagnosis, and treatment planning
3. Evidence-informed drug dependence treatment
4. Drug dependence treatment, human rights, and patient dignity
5. Targeting special subgroups and conditions
6. Addiction treatment and the criminal justice system
7. Community involvement, participation, and patient orientation

¹⁶ Jeffrey Clemens, "Opium in Afghanistan: Prospects for the Success of Source Country Drug Control Policies," *Journal of Law and Economics* 51, no. 3 (2008): 407–432; Vanda Felbab-Brown, *Shooting up: Counterinsurgency and the War on Drugs* (Washington, D.C.: Brookings Institution Press), 2010; Tullis, *Handbook of Research*, 60.

8. Clinical governance of drug dependence treatment services
9. Treatment systems: policy development, strategic planning, and coordination of services¹⁷

The recommendations are unique, because they were designed to address typical institutional barriers in developing countries. While these nine components are the ideal mechanism to examine individual needs, resource capacity, and recovery capital within the drug treatment program, they fail to include broader concepts from post conflict countries—such as violence stemming from insurgency, cultural cues, and proximity to the drug trade—that can also hinder development. To grasp the full context, the nine UNODC/WHO components along with the evaluation framework built in the literature review below (Table 2, Table 3 and Table 4) will be combined to identify the degree to which political and economic barriers affect each region.

This thesis applies this framework to assess three provinces (Kabul, Kandahar, and Badakhshan) with varying constraints to show how community resources sway an addict's ability to quit drugs successfully. The goal is to understand how civil institutions collaborate and provide insights into ways communities can play an active role. Social factors such as poverty, unemployment, mental illness, health, education, drug trafficking, and poppy production will be gauged to grasp the influence that socio-economic systems have on effective treatment programs. Community capabilities will be determined by consistency of procedures: in other words, the more of the nine principles a treatment program follows, the more likely there is high quality intervention. This thesis suggests that the most successful provinces will be those which follow the nine UNODC/WHO principles, have strong community networks, and adapt quickly to Afghanistan's unique circumstances. Furthermore, this research recommends creating a more tailored plan for patients to manage conflict and environmental factors.

Each case study will be evaluated to better understand how security, and policy context plays a role in building effective drug treatment programs. The thesis delivers a comparative assessment of drug treatment quality in each of the three provinces, and

¹⁷ UNODC and WHO, "Principles of Drug Dependence Treatment," last modified March 2008, <http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf>.

contextualizes and explains these outcomes with an analysis of social, economic, and psychological factors in each. There are a number of provinces this thesis could examine; however the selection was limited to enable analytical consistency, more in-depth research, and accurate description of the environmental and cultural factors present in Afghanistan. Table 1 gives estimates of the number of illicit drug users in each of the country's geographic regions. Although the exact number of addicts is difficult to determine, the data illustrate that drug use is persistent and rampant in all provinces. Since each district is somewhat similar in the prevalence of addiction rates, there were few constraints in selecting case studies. Regions were selected by the number of drug users, population rates, their influence in the drug industry, and most importantly, the ability to access data from their drug treatment programs.

Table 1. Number of Illicit Drug Users and Annual Prevalence by Region¹⁸

	Number			Prevalence (%)		
	Estimate	Low	High	Estimate	Low	High
Central	253,000	217,000	288,000	6.5	5.6	7.4
Eastern	87,000	67,000	107,000	6.3	4.8	7.8
North Eastern	82,000	69,000	95,000	6.1	5.1	7.1
Western	101,000	88,000	114,000	5.9	5.1	6.7
Southern	107,000	86,000	128,000	7.2	5.8	8.6
Northern	171,000	137,000	204,000	7.2	5.8	8.7
Afghanistan	800,000	660,000	940,000	6.6	5.4	7.7

The three case studies that were selected are: Kabul in the center of the country, Kandahar in the south, and Badakhshan in the north. They all have unique socio-economic environments, high addiction rates, and have been researched by multiple counter-narcotic experts. When analyzing the nine components in each province, special attention will go towards the quality of intervention, the role of the community, and the influence of drug treatment policy at the national level. As far as outcomes, Kabul is expected to have the highest recovery capital score and quality of interventions, because it is the capital of Afghanistan, it is linked to vibrant markets, and has the largest

¹⁸ National Estimates are rounded to the nearest 10,000 users; UNODC, *Drug Use in Afghanistan: 2009 Survey*, 6.

percentage of policy makers and academics. If the hypothesis is correct, the other two provinces will be significantly weaker because they are both heavily involved in the drug industry, have more rural regions, and have less economic prospects for residents. Badakhshan may be slightly more advanced in its quality of interventions, because it has lower addiction rates and is a relatively stable region in terms of security. Kandahar is expected to be the weakest in terms of recovery capital, because of its instability and strong ties with the Taliban.

The findings from this thesis should assist in explaining the interaction between drug treatment programs and broader socio-economic context in post-conflict countries. Moreover, the analytical framework employed can be used as a template for more complex addiction-prone regions. The nine UNODC/WHO principles serve not only as a quantitative tool to measure effectiveness, but also as reference points to ensure a more localized approach is developed while maintaining international uniformity. If treatment programs are ineffective yet adhere to standard procedures, this reflects the need to change counseling techniques or social programs to ensure that cultural or environmental concerns are addressed. The variation in terms of socio-economic indicators will allow for an evaluation of how much these factors affect the potential for success of drug treatment programs, the core question with which this thesis is concerned.

II. LITERATURE REVIEW

In 2003, 85% of Afghanistan's approximately 26 million inhabitants depended on agriculture to make a living.¹⁹ In 2009, the UNODC estimated that "245,200 households engaged in illicit opium poppy cultivation in Afghanistan. That is 1.6 million people, equating to 6.4% of the total population of Afghanistan."²⁰ When you consider that poppy accounts for 46 percent of its gross domestic product, it is easy to understand why proposing new alternatives for development in Afghanistan remains challenging.²¹ Afghanistan is unique because it has an extensive history producing drugs. International experts have experimented with new strategies in development, but programs have been ineffective because Afghanistan lacks the capacity to manage its own institutions, struggles to diversify its agricultural products, and fails to provide a sufficient social safety net for the underprivileged—especially those who are struggling with drug addiction.

The objective of this literature review is to analyze existing scholarship on how addiction rates are connected to the drug trade. The literature review yields four hypotheses as to why drug treatment has not been effective thus far: (1) drug trafficking weakens socio-economic and political infrastructure, (2) weak economic markets deter community involvement and opportunity, (3) poor governance permits corruption which reduces the prioritization of social programs, and (4) psychological interventions are limited in knowledge and expertise. Together these hypotheses infer that the quality of provincial drug treatment programs and their ability to adhere to the nine UNODC/WHO good practice components will be dependent on how they manage structural/institutional constraints (at the provincial and national level) as well as psychological interventions (at the individual level). Lastly, the literature review will create a comparative framework to

19 U.S. GAO, "Foreign Assistance: Lack of Strategic Focus and Obstacles to Agricultural Recovery Threaten Afghanistan's Stability," Report to Congressional Requestors (Washington, DC, 2003), 6.

20 UNODC, *Alternative Livelihoods in Afghanistan: Time Frame: June 2010 – July 2012* (UNODC, 2010), 1.

21 Clemens, "Opium in Afghanistan," 407.

analyze these various components, showing how hypotheses are interconnected and illustrating that efforts must be addressed in tandem for successful outcomes in reducing drug dependence.

A. DRUG TRAFFICKING—WHAT HAS BEEN ACCOMPLISHED THUS FAR?

There are three main schools of thoughts regarding the best ways to mitigate threats associated with opium consumption. These different strategies are important to evaluate, because they explain why past counter-narcotic policies have weakened institutions in Afghan's civil society. The first method is the supply-side strategy; its main objective is to reduce production of drugs by targeting areas of origin, where narcotics are cultivated, processed, and trafficked. This is accomplished through forced eradication of illicit crops, creating alternative developmental programs, or interdiction and seizure operations.²² Once supplies are limited, there will be an increase in opium costs, which will deter drug use internationally.²³ From this perspective, enforcement is the only way to permanently fix the social, economic, legal, and health constraints associated with the drug trade.²⁴ Supply-side supporters see corruption as the prime problem in Afghanistan. Moreover, they perceive the demand-side as dangerous when done half-heartedly; if development fails, which it has in the past, it could make Afghans further aligned with the Taliban.²⁵

The second option is the demand-side strategy which alternatively recommends decreasing the social demand for drugs. This can be implemented by providing

²² Scott R. Whittenburg, "Opium in Afghanistan: Lessons Learned from the Counterdrug Strategies of Columbia" (master's thesis, Naval Postgraduate School, 2009), 12.

²³ Pierre-Arnaud Chouvy, *Opium: Under covering the Politics of the Poppy* (London: I.B. Tauris & Co., 2009), 143.

²⁴ Prior to 2009, most of donor funds went to supply-side approach. According to the GAO report, 992.2 million went towards eradication, 966.3 million went towards interdiction, 382.5 million went towards rule of law/justice, 35.4 million went towards public information, 17.6 million went towards drug demand, and 110.9 million went towards program development and support from 2005–2009. Only 0.7% of U.S. funding for counter-narcotics went towards drug demand reduction; U.S. GAO, "Afghanistan Drug Control: Strategy Evolving and Progress Reported, but Interim Performance Targets and Evaluation Justice Reform Efforts Needed," Report to Congressional Addressees (Washington, DC, 2010), 4–5.

²⁵ Ethan Nadelmann, "Drugs," *Foreign Policy*, no. 162 (2007): 30.

preventative public awareness campaigns and drug treatment programs to combat addiction.²⁶ Demand-side proponents propose that combatting addiction is much cheaper,²⁷ minimizes corruption,²⁸ is less complex for the international community, requires fewer resources, creates jobs, and diversifies markets so addicts do not have to be involved in the drug trade. It requires investment from the international community in the beginning, but organizations contend it is worthwhile because Afghans will be required to take ownership of their local economies; in turn, these programs will become more sustainable. This line of reasoning suggests that stronger institutions deter drug trafficking because they instill a set of rules and structure which are vital in managing corruption and building effective drug treatment programs.

The last option is legalizing opium so efforts and finances are not spent building an agricultural market in Afghanistan that is not profitable or sustainable. These supporters claim that neither supply nor demand strategies are strong enough to stop the drug trade. In their opinion, once Afghanistan stabilizes, opium production and trafficking are likely to transfer to another state, and other areas will fill the void to benefit economically.²⁹ Some argue that legalization is the answer because it would allow for partnership between regional buyers and international produce firms.³⁰ It would reduce funds for belligerents, because “the government would capture the financial gains

26 Chouvy, *Opium: Undercovering the Politics of the Poppy*, 143; Tullis, *Handbook of Research*, 57–71.

27 Liana Wyler, “International Drug Control Policy,” U.S. Congressional Research Service (Washington, DC, 2009), 30; Olivier Maguet and Murtaza Majeed, “Implementing Harm Reduction for Heroin Users in Afghanistan, the Worldwide Opium Supplier,” *International Journal of Drug Policy* 21, no. 2 (2010): 119.

28 Clemens, “Opium in Afghanistan,” 414; The GAO’s reasoning was that, “eradication unduly punished and alienated farmers for making a ‘rational economic decision’ while ignoring the profits gleaned by traffickers and insurgents.”; U.S. GAO, “Afghanistan Drug Control,” 11

29 Gives an example of the Balloon Effect; where the massive offense against the Cali cartel in Columbia exacerbated the drug problem in Brazil and the Southern Cone; Frank O. Mora, “Victims of the Balloon Effect: Drug Trafficking and U.S. Policy in Brazil and the Southern Cone of Latin America,” *The Journal of Social, Political, and Economic Studies* 21, no. 2 (1996): 138; Past experiences suggest that new, “countries might still enter the market, with varying degrees of speed, whether in opiate production, trafficking, or consumption.”; Letizia Paoli, *The World Heroin Market: Can Supply be cut?* (Oxford: Oxford University Press, 2009), 67.

30 Nadelmann, “Drugs,” 30; Felbab-Brown, *Shooting up*, 28.

in the form of taxes.”³¹ A more legal market would in turn make Afghanistan’s government more credible and legitimate.³² Legalization would “benefit those who struggle with drugs by reducing the risks of overdose and disease associated with unregulated products, eliminating the need to obtain drugs from dangerous criminal markets, and allowing addiction problems to be treated as medical rather than criminal problems.”³³

While this option does sound less expensive and complex, demand-side and supply side followers argue that legalization is not feasible at this time, because it is not globally supported. One expert contends that the “total supply (production and stocks) of opiate raw materials has exceeded the total demand for opiates needed for medical and supply purposes.”³⁴ The value of the poppy would also go down because Afghanistan would be unable to compete with countries such as India and Australia, which already have the facilities and have mastered refining techniques.³⁵

The challenge with drug trafficking lies in the fact that it is an international concern; multiple states must collaborate together to find a solution. Since legalization is not an option, the solution to the drug trade lies somewhere in a balance between the supply and demand strategies. Enforcing drug trafficking is crucial, but has been proven to have serious ramifications if done independently; it has weakened socio-economic and political infrastructure in the past. Afghanistan’s best option would be to rebuild drug treatment and welfare programs that alleviate poverty and unemployment. If there is less desire for drugs within Afghanistan, it will more difficult to recruit individuals in the

31 Felbab-Brown, *Shooting up*, 28.

32 Nadelmann, “Drugs,” 30.

33 Nadelmann, “Drugs,” 28.

34 “Current Supply of Legal Opium Adequate to Meet World Demand, Says INCB President.” International Narcotics Control Board website, accessed October 25, 2011, http://www.incb.org/incb/en/press_release_2007-11-12_01.html.

35 Techniques like poppy Straw Extraction (PSE) are far more advanced than anything Afghanistan could offer. Poppy straw is the name applied to all parts (except the seeds) of the opium poppy plant, after mowing, from which narcotics can be extracted. This method is important because it extracts morphine from the capsules and upper parts of the poppy stem after mowing to manufacture opium alkaloids; Robert Gregg. “The United Nations and the Opium Problem,” *The International and Comparative Law Quarterly* 13, no. 1 (1964): 102–104.

drug trade. If Afghans have an increased awareness about the harmful effects of drug production and have social services to assist them during the transition, they may be more eager to switch to an alternative occupation.

Since the previous section suggests that the best way to combat the drug trade is through a balance of supply-side and demand-side strategies, these next three sections will create a framework for the case studies. The goal is to create a more integrated approach to development. By connecting the two sets of literature (economic and security/governance) and adding a psychological component, this thesis should be able to identify key provincial constraints to consider when developing drug treatment programs in Afghanistan.

B. ECONOMIC COMPONENT

This section evaluates how donor agencies and regional experts have attempted to respond to Afghan poverty in the past and gives recommendations on ways to move forward. This component is relatively aligned with the supply-side strategy and argues that economic programs will decrease poverty rates,³⁶ reduce the insurgent movement, and create a more unified community approach. Since addiction is linked to employment in Afghanistan, preventative education and interventions need should be included in the economic reconstruction plan.

From the economic standpoint, greed or grievances start civil wars. More jobs reduce conflict because rebels will have less desire to join insurgent groups if their complaints are managed.³⁷ This thesis argues that the best way to improve transparency and corruption is by including welfare services, like drug treatment programs, that direct services to the poor and advocates for them. If society rejects addicted ex-combatants, they will struggle with the transition and mostly likely object to new civil structures. A

³⁶ David Mansfield, *Between a Rock and a Hard Place: Counternarcotic Efforts and their Effects in Nangarhar and Helmand in the 2010–11 Growing Season* (Research Report: AREU, 2011), 10; U.S. GAO, “Securing, Stabilizing, and Reconstructing Afghanistan,” Congressional Report (Washington, DC, 2007), 10.

³⁷ Andrew Beath, Fotini Christia, and Ruben Enikolopov, *Winning Hearts and Minds Through Development* (Massachusetts: Massachusetts Institute of Technology, 2011), 2; Paul Collier, Anke Hoefler, and Dominic Rohner, “Beyond Greed and Grievance: Feasibility and Civil War.” *Oxford Economic Papers* 61, no. 1 (2009): 12.

community referral system for social services would increase the actors involved, introduce new formal practices at the community level, and improve accountability.

In the past, experts have tried to incorporate economics by constructing alternative livelihood programs, which have incentivized diversification of new crops.³⁸ Diversification is influential in breaking the drug cycle and reducing addiction rates; however many report it ineffective in Afghanistan because it is not supported by stronger institutions.³⁹ Projects approved are known to be “highly-visibility, quick-impact” and are often perceived as too risky in rural regions.⁴⁰ The UNODC recommends fighting the drug trade and poverty simultaneously, but this is difficult to manage if communities lack institutional capacity and are slow to respond to political constraints.⁴¹ By including social services, like drug treatment, to alternative livelihood programs there will be less uncertainty regarding success of project, because processes will be embedded in civil society. Having a formal social welfare system in place will improve transparency for actors involved, create a more localized approach, and implant long-term objectives.

While there is no single answer to ending poverty, there are steps that the international community and Afghanistan can take to improving an individual addict’s financial situation. Table two lists economic components that are influential in improving recovery capital in Afghanistan. In turn, these questions can help to capture the variation between provinces and will be used to comparatively analyze the three case studies. To improve the economic situation, a first step would be to implement incentives in policies and financial institutions so that the poor benefit. To further assist the poor population, community programs should be networked so that Afghans know where to find resources. If employment and welfare programs are linked to drug treatment programs, it

38 Paula Kantor and Adam Pain, *Rethinking Rural Poverty Reduction in Afghanistan* (Kabul: AREU, 2011), 1–4.

39 Chouvy, *Opium: Undercovering the Politics of the Poppy*, 163; Paula Newberg, “Surviving State Failure: Internal War and Regional Conflict in Afghanistan’s Neighborhood,” in *Rethinking the Economics of War: The Intersection of Need, Creed, and Greed*, ed. Cynthia Arnson and William Zartman (Baltimore: John Hopkins University Press, 2005), 207; Robert Looney, “Trends: Afghanistan Strung Out,” *The Milken Institute Review* (2009): 15.

40 Felbab-Brown. *Shooting up*, 145.

41 Looney, “Trends,” 14.

may be easier for addicts to adjust to their old environment. Instead of turning to drugs, addicts can seek counsel from a case worker or a community support group. Additionally, diversifying the market while simultaneously reducing corruption will push addict to turn to legal crops.

Table 2. Economic Components of Drug Treatment Center Assessment

What is the poverty rate? Are there adequate welfare services for poor?	Are there enough employment opportunities for locals?	Is technology available? Does it link other community networks?	Are market's diverse? Is opium the main source of income?	Are financial institutions structured in a way that incentivizes the rich to invest in welfare programs?
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C. SECURITY/GOVERNANCE COMPONENT

This section evaluates security/governance in Afghanistan and gives recommendations on ways to improve drug policies. While security and governance are two separate issues, they are connected together in this literature review because a counter-narcotic approach requires both elements to have been addressed simultaneously. A strong policing system ensures the stability necessary for economic diversification and productivity; and a credible government complements enforcement and reduces illegal acts. This component is aligned with the supply-side strategy and claims that accountability and transparency within government along with a stronger justice system would alleviate corruption.⁴² By adding the drug treatment component to security/governance, programs will be further enriched because more funds would be prioritized to local institutions.

From the standpoint of security/governance, conflict is not perpetuated by greed but rather created from economic opportunities in the Afghan conflict.⁴³ While this is mainly an economic concern, it becomes a governance issue when leaders cannot provide

⁴² Fatima Ayub and Sari Kouvo, "Righting the Course? Humanitarian Intervention, the War on Terror and the Future of Afghanistan," *International Affairs* 84, no. 4 (2008): 651.

⁴³ Amson, "The Political Economy of War: Situating the Debate," 11.

services to their impoverished population, because money is not being distributed at the government level in a way which benefits civil society. For example, “seven percent of the country’s population of 24 million profited from the \$2.3 billion in trade.”⁴⁴ Instead of putting attention towards reconstruction, officials should create a stronger political structure that encourages private actors to react responsibly and invest in revenues.⁴⁵ More dependable institutions would improve relationships that have been hurt by “the gradual decline of the security situation.”⁴⁶ As enforcement improves, drug trafficking should become riskier which will cause Afghans to switch to new markets.

While security/governance is crucial to development, it is sensitive issue because it also concerns a nation’s sovereignty. The United States Government Accountability Office (GAO), states that, “illicit drug trade undermines virtually every aspect of the U.S. and Afghan governments’ efforts to secure and stabilize Afghanistan.”⁴⁷ D’monte recommends institutional reform as well as assistance from intelligence agencies; he feels they need “to be brought within the purview of law and supervision by parliament as well as made accountable before the judiciary with personal liability for doing what is an offence insofar as against any individual, state or society.”⁴⁸ Having international standards to manage drugs would be beneficial but difficult to coordinate. Even with strong international intentions, policies are often enforced in a way that punishes the farmer and benefits the drug dealer. Putting more attention on policies that punish higher officials would help insurgent groups see the severity of the situation.

Including drug treatment would further decrease addiction as well as increase international involvement in institution building; the issue of sovereignty would not be as concerning, because it would be done at the local level. To build transparent institutions,

⁴⁴ Newberg, “Surviving State Failure,” 207.

⁴⁵ Jonathan Goodhand, “Corruption or Consolidating the Peace? The Drug Economy and Post-Conflict Peacebuilding in Afghanistan,” *International Peacekeeping* 15, no. 3 (2008): 406–407.

⁴⁶ Ayub and Kouvo. “Righting the Course?” 651.

⁴⁷ “The production of opium competes with the country’s licit agricultural industry, provides funds to insurgents, and fuels corruption.”; U.S. GAO, “Afghanistan Drug Control,” 1.

⁴⁸ Darryl D’Monte, “Corruption, Safety and Environmental Hazard in Asian Societies,” *Economic and Political Weekly* 35, no. 33 (August 2000): 2967.

research suggests that organizations should focus on improving accountability practices, making statements public and simplifying systems/branches so that rules and guidelines are straightforward.⁴⁹ Afghanistan should tailor its own model when pursuing foreign aid and have a mix of bottom-up and top-down strategies to ensure both locals and the central government are contributing equally in regards to decision making.⁵⁰ Afghanistan should prevent “incentives for the growth of the combat and shadow economies—including the tightening of borders which prevent legal cross border trade, the repression of Islamic groups, human rights abuses and the cutting back of public services.”⁵¹ While these recommendations for fixing governance are useful, some policy ideas may not be realistic considering Afghanistan has minimal resources and funds. The justice and police system is too weak to implement and enforce drug policies.⁵² Since a high percentage of police are either addicted or involved in the drug trade, the international community will need to oversee programs, at least initially. There also needs to be a plan in place so that the Afghan ownership once international troops leave Afghanistan.

Managing corruption will improve the drug trafficking situation, ensure that money is going to the poor, and help stabilize Afghanistan’s government; nevertheless it is not the overall solution to ending the population’s dependency on drugs. These efforts need to be combined with socio-economic principles to be most efficient. Table three provides a few recommendations to consider when linking security/government to the case studies. To build strong treatment programs, Afghanistan needs to first improve its security, justice, and police systems to ensure that drug policies are enforced. To minimize corruptions, policies can be created strategically to deter drug trafficking. International police may want to initially assist in monitoring and enforcing new policies and procedures to reduce the chance of new institutions losing credibility. Lastly, drug treatment should be provided to police and prisoners to reduce criminal acts in society.

49 Sue Cavukk and M Sohail, “Increasing Strategic Accountability: A Framework for International NGOs,” *Development in Practice* 17, no. 2 (April 2007): 247.

50 Jonathon Goodhand, “Aiding Violence or Building Peace? The Role of International Aid in Afghanistan,” *Third World Quarterly* 23, no. 5 (2002): 854.

51 Jonathon Goodhand, “From War Economy to Peace Economy: Reconstruction and State Building in Afghanistan,” *Journal of International Affairs*, 58 (2004): 168.

52 Ayub and Kouvo, “Righting the Course,” 656.

Table 3. Security/Governance Components of Drug Treatment Center Assessment

Is the region secure?	Is corruption managed?	Are there enough qualified police working in the province? Are there special programs for addicts who are policemen?	Is there drug treatment services provided in prisons?	Is the justice system enforcing drug policies?
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D. PSYCHOLOGICAL COMPONENT

This subcategory seeks to understand psychological barriers at both the individual and community levels that prevent rehabilitation clinics and drug treatment programs from being effective. The psychological component suggests that the best way to reduce opium consumption is by: improving social challenges, enhancing recovery capital, and stimulating drug awareness programs. Since there is little research on mental health in Afghanistan, this section will assess the arguments of political scientists and psychologists whose primary focus and expertise is on developing post conflict societies.

Drug treatment centers often lack the capacity to help addicts; it is difficult to find qualified counselors and pharmacists, who are experienced in behavioral psychotherapy and/or specializes in drug addiction.⁵³ According to Rawson, “there are no accredited addiction counselor training programs in the entire Middle East.”⁵⁴ Treatment centers lack administrative personnel and social workers, which provide structure when an addict decides to reenter the community. Additionally, language skills and cultural training are oftentimes absent in more diverse/rural regions. Even if outside resources are brought into Afghanistan, locals will need to be trained on how to best assist patients and families in quitting drugs.

Drug treatment centers’ capacity could be improved by “publish[ing] documents that aim to reduce the gap between research and practice” and creating an academic

⁵³ David MacDonald, *Afghanistan’s Hidden Drug Problem: The Misuse of Psychotropics* (Kabul: AREU, 2008), 5; U.S. State Department, “Demand Reduction Program: Afghanistan,” last modified May 13, 2010, <http://www.state.gov/p/inl/rls/fs/141848.htm>.

⁵⁴ Richard Rawson, “Building an Addiction Workforce in the Middle East: A counselor Training Program Partnership between Kasr Al-Ainy and UCLA” (Washington, DC: Middle East Institute Viewpoints: Public Health in the Middle East, 2011), 23.

network within society.⁵⁵ Many believe this gap originated from misunderstandings of addiction; individuals do not always perceive it as a real medical concern. To increase evidence-based research, scholars should “make relevant research findings available to practitioners, in formats that are useful to busy treatment personnel whose daily patient responsibilities often preclude them from scouring journal articles or from performing extensive literature searches.”⁵⁶ Another approach encourages organizations to strengthening drug treatment programs by enhancing employee’s skills through trainings and conferences.⁵⁷ More educated counselors and pharmacists creates more legitimacy in treatment programs and provides a framework for social change in the policy realm. As addicts become less impoverished and new businesses are created, there will be more desire to advocate for issues such as human rights concerns and the drug trafficking market.

Intervention programs will also need to be assessed to ensure they are addressing cultural concerns while maintaining an international standard. A key controversy in this regard is the use of methadone and harm reduction services in drug treatment clinics. In addition, rural treatment centers are using traditional approaches rather than evidence-based research. For example, one clinic used short-term attempts to alleviate withdrawal; addicts end up relapsing immediately because they did not know how to deal with physical cravings, daily routines, or stressful situations.⁵⁸ Afghan clinics should accommodate cultural concerns, but also be realistic when decreasing addiction rates.

Teaching Afghan addicts how to manage behavioral urges and cope with stress will be extremely difficult, especially considering the impact that war has on them. War oftentimes creates a sense of myopic behavior, which can cause fragile states to make poor policy decision and for individuals to choose risky lifestyles. Many Afghans suffer

55 Patricia Marinelli-Casey, Catherine Domier, and Richard Rawson, “The Gap between Research and Practice in Substance Abuse Treatment,” *Psychiatric Services* (2002): 984.

56 E. Gordis, “Linking Research with Practice: Common Bonds, Common Progress,” *Alcohol, Health and Research World* 15, no. 3 (1991): 173.

57 St. Walters et al., “Effectiveness of Workshop Training for Psychosocial Addiction Treatments: A Systematic Review,” *Journal of Substance Abuse Treatment* 29, no. 4 (2005): 283.

58 Macdonald, *Afghanistan’s Hidden Drug Problem*, 14.

from mental illnesses such as depression, anxiety, and post-traumatic stress disorder (PTSD). Mental health issues increase the likelihood of drug dependency because it intersects with “social issues associated with their substance use that make diminishing or abstaining from substance use extremely difficult.”⁵⁹ Even though Afghans have expressed a desire to seek treatment, they cannot conceptualize how to break the physical and the emotional parts of the addiction. Some of the most well-known techniques to help individuals are motivational interviewing, cognitive behavior counseling, family-based treatment, and contingency management interventions which will be further discussed in case studies.⁶⁰

Psychologists and political scientists argue that counseling is best done through PTSD and Disarmament, Demobilization, and Reintegration (DDR) programs.⁶¹ Assisting ex-combatants and victims of war with psychological trauma helps equip them to deal with post war economy, ensures reintegration, and reduces the chance of them becoming a threat to society.⁶² Research has also been shown that, “the sooner the diagnosis is made the better the chance of therapeutic success” for PTSD patients.⁶³ Helping Afghans manage psychological concerns before reintegration will shorten the length of treatment needed and allow for funding to go to new avenues.

While ex-combatants are a good population group to target, psychologists should sensitive to their challenges and create a more tailored approach. Drug treatment programs could set addicts up for failure if their ability to stay of drugs feels unattainable.

⁵⁹ Clinic allowed patients to use painkillers and tranquilizers for six months after leaving treatment. Patients were at a disadvantage because they were experiencing withdrawal outside of the clinic; Victoria Smye et al., “Harm Reduction, Methadone Maintenance Treatment and the Root Causes of Health and Social Inequities: An Intersectional Lens in the Canadian Context,” *Harm Reduction Journal* (2011): 3.

⁶⁰ Kimberley Kirby et al., “Substance abuse treatment providers’ beliefs and objections regarding contingency management: Implications for dissemination,” *Drug and Alcohol Dependence* 85 (2006): 19–27; Patricia Marinelli-Casey, Catherine Domier, and Richard Rawson, “The Gap between Research and Practice,” 984–986.

⁶¹ Lynn August and Barbara Gianola, “Symptoms of War Trauma Induced Psychiatric Disorders: Southeast Asian Refugees and Vietnam Veterans,” *International Migration Review* 21, no. 3 (1987): 830.

⁶² Alpaslan Özerdem, “Disarmament, Demobilization and Reintegration of Former Combatants in Afghanistan: Lessons Learned from a Cross-Cultural Perspective,” *Third World Quarterly* 23, no. 5 (2002): 968.

⁶³ Roger Gabriel and Leigh Neal, “Lesson Of The Week: Post-Traumatic Stress Disorder Following Military Combat Or Peace Keeping,” *British Medical Journal* 324, no. 7333 (2002): 341.

Reintegrating into a new environment, starting a job, and coping with psychological trauma could be too much pressure. If ex-combatants are pushed too quickly, they may not seek medical help, which is known to be a common response for victims. Strategists should also be careful in giving preferential treatment, because it could cause a backlash within civil society.⁶⁴ The international community does not want to discourage those who have been loyal to rebuilding Afghanistan. Since there are many Afghans suffering from drug dependency and minimal rooms in treatment programs, confrontation could easily occur within various groups. To see improvement in DDR programs, they must be, “designed in such a way that the reintegration trajectories of participants can be usefully compared with those of nonparticipants.”⁶⁵ Designating alternative programs to assist individuals with PTSD will be beneficial in helping mitigate a backlash and prioritize mental illness.

Since Afghanistan is unique in its conflict and overall capacity, additional psychological components should be considered when evaluating the case studies. Table four distinguishes key constraints which prohibit the enhancement of drug trafficking, economic, and security/governance components. For example, confidentiality is a variable because Afghan addicts do not want to be ousted by their community or subjected to severe rejection from family or friends. Self-help groups and preventative campaigns could assist in relieving fear and rejection. If there is less stigmatization, there is a greater chance that ex-combatants will reintegrate back into the community. Small additions like these could significantly decrease addiction rates and further link larger-scale issues.

⁶⁴ Özerdem, “Disarmament, Demobilization and Reintegration,” 973.

⁶⁵ Macartan Humphreys and Jeremy Weinstein, “Demobilization and Reintegration,” *The Journal of Conflict Resolution* (2007): 561.

Table 4. Psychological Components of Drug Treatment Center Assessment

Do Health Networks Collaborate to Improve Recovery Capital?	Are there systems in place to assist ex-combatants with PTSD?	Are programs confidential?	Are there enough trained counselors and pharmacists?	Are clinics giving medication to patients to fight urges?	Are patients being taught behavioral techniques to manage and cope with urges?
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E. CONCLUSION—CLOSING THE LITERATURE GAP

Both trafficking and addiction will continue to be an ongoing problem for Afghanistan. Strategies that have been used to manage drug trafficking (e.g., crop substitution, eradication, and legalization) have widened the poverty gap within Afghanistan. Building stronger social service programs for addicts, will lessen the poverty gap and reinforce the need for more transparent and legitimate institutions. There is a great deal of information on how to create a “successful” rehabilitation program, but little on how to develop clinics with tools to manage cultural diversity, opium cultivation, and conflict. Afghanistan’s environmental, political, and economic constraints make it difficult to give a cookie-cutter response that will be applicable in all circumstances. It is also difficult to compare it to Western practices because Afghans have different views on women’s rights, family responsibilities, and religious views.

Since drugs are so ingrained in Afghanistan’s sociopolitical, economic, and cultural context, the best solution is to connect the structural issues of security/governance and economic dimensions to psychological constraints. Addiction rates will continue to increase if drug treatment center capacity is not developed, if unemployment and poverty programs are not introduced, if high officials misuse funds, and if economic markets are not implemented to divert drug trafficking. Individuals will be more successful in quitting if they are not influenced by drug users, if they are in regions where there is less ethnic conflict, and if they have stronger family or community support. Understanding what services are available to the public and how they fit Afghanistan’s societal norms will be crucial to ensuring that the nine UNODC/WHO good practice components are implemented successfully in treatment programs. Afghans

need to be able to trust that the government and international organizations have their best interests in mind. Creating new techniques for each region will increase the likelihood of less addiction and generate community involvement, which is essential in the reconstruction phase.

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III. COMPARATIVE ASSESSMENT OF DRUG TREATMENT PROGRAMS IN THREE AFGHAN PROVINCES

A. CASE STUDY COMPARATIVE METHOD

This chapter assesses how well Kabul, Kandahar, and Badakhshan regions perform along the nine UNODC/WHO good practice components in order to better understand how individual and socio-economic indicators affect drug treatment program capabilities. The purpose of evaluating provincial capacity is to better understand what key variables prevent addicts from being successfully treated, so that policy makers can create a more comprehensive community approach. This evaluation is done by assessing Kabul, Kandahar, and Badakhshan's ability to allocate resources to addicts by comparing recovery capital—the amount of individually tailored and societal support available for an addict to quit successfully.⁶⁶ Recovery capital in each province is measured instead of relapse rates, because individual capabilities differ between addicts. For example, some patients have been able to quit on motivation alone while others have an abundance of resources and still end up relapsing. While quitting “cold turkey” is not recommended and has been proven less effective in the long run, the example illustrates how community factors can influence an individual's motivation and confidence to maintain strong throughout the process of quitting. If addicts cannot see their situation improving by seeking help, they may remain ambivalent. By examining provincial recovery capital, the thesis can thoroughly understand addict's triggers and link them to community resources.

While the term “recovery capital” best explains how a community can collectively engage and empower addicts through physical, emotional and social triggers, it is not the only variable that must be measured. It does not describe how programs and policies can be introduced at a national level to empower local participation. Post-conflict countries, like Afghanistan, have regions that are vulnerable to drug addiction. These

⁶⁶ Alexandre B. Laudet, “The Road to Recovery: Where are we going and how do we get there? Empirically-driven conclusions and future directions for service development and research,” *Substance Use Misuse* 43, no. 12–13 (2008): 2012.

high risk areas are often prone to conflict, are near border areas that are less secure, or in highly dense regions as a result of migration. The uncertainty of survival produces inadequate socio-economic infrastructure that weaken family and community networks. The decline in collective action becomes a national concern because political policies become more difficult to initiate, develop, and enforce. Individuals begin to lose hope in their social support groups and turn to new devices to manage their pain and suffering. To fully assess drug treatment programs, Afghanistan will need to be evaluated at the individual level (to see how perceptions effect addicts motivation and confidence), at the local level (to see how the community is engaged), and at the national level (to see if there is a solid political economic framework.) This thesis will focus on the provincial level, but connect local and national barriers which can keep communities from providing services to their citizens.

B. RESULTS

A review of the case studies makes it clear that Afghanistan has a great deal of variation in drug treatment capabilities at the provincial level. The differences become even more apparent as community leadership and recovery capital are evaluated to explain inconsistencies. Table 5 summarizes my assessment of each studied region's ability (low, medium, or high) to adhere to the UNODC and WHO nine components; and the following sections then provide the deeper analysis upon which this summary assessment rests. I score Kabul as the strongest province, because it had the largest amount of resources, community networks, and research capabilities. While these results were predicted, since it is the capital of Afghanistan, it should be noted that Kabul has much work that must be done before it meets the standards of more developed countries. The study finds that Kabul is still reliant on donors, has high corruption within its administration, and scores poorly on a few of the nine components.

Badakhshan and Kandahar score similarly in my assessment; however, there are a few dimensions that suggest that Kandahar may be a bit stronger when it comes to distributing drug treatment resources to rural regions. The most surprising result is that Kandahar ranks equally to Kabul on a few of the components. This was unexpected since the initial assessment hypothesized that insecurity, poppy cultivation, and weak markets

in Kandahar would prevent the region from providing adequate care to its poor population. Its increased resource capacity can be attributed to its strong tribal networks and donor funds allocated to combat counter-narcotics and conflict. Local tribal leaders in Kandahar are able to use their linkages to their advantage and create systems quickly. Instead of starting from scratch, they revised their previous health structure to include drug treatment which enhanced the quality and coordination of community services at the provincial level. While their tribal linkages were extremely useful, they also prove to be a disadvantage when mission objectives are contradictory.

While Badakhshan is seen as the weakest of the three case studies, it is strong when compared to other provinces in Afghanistan. Areas like Badakhshan, Nangahar, Herat, and Kandahar receive more funding for drug treatment, because they have high population density, their residents are perceived as high-risk, they are involved in the illicit drug industry, and/or have a large percentage of injection drug users (IDUs). The reason why Badakhshan has decreased recovery capital is because its extreme poverty, rugged terrain, and less donor funds which make it difficult to coordinate services to its residents. While it has the basic infrastructure set up in the provincial capital and has specialized in a few target populations, it lacks resource capabilities and awareness in getting services to more rural regions.

Table 5. Drug Treatment Capabilities in Kabul, Kandahar, and Badakhshan Province

UNODC/WHO COMPONENTS	KABUL CASE STUDY	KANDAHAR CASE STUDY	BADAKHSHAN CASE STUDY
Availability and Access to Drug Treatment	MEDIUM	LOW/MEDIUM	LOW/MEDIUM
Screening, Assessment, Diagnosis, and Treatment Planning	MEDIUM	LOW/MEDIUM	LOW
Evidence Informed Treatment	MEDIUM	LOW	LOW
Human Rights and Patient Dignity	MEDIUM/HIGH	LOW	LOW/MEDIUM
Targeting Special Groups and Conditions	MEDIUM/HIGH	MEDIUM	LOW/MEDIUM
Criminal Justice System	LOW/MEDIUM	LOW/MEDIUM	LOW
Community Involvement	MEDIUM	LOW/MEDIUM	LOW
Clinical Governance	LOW/MEDIUM	LOW	LOW
Coordination of Services	LOW/MEDIUM	LOW/MEDIUM	LOW

1. Component #1: Availability and Access to Drug Treatment

My review of research concerning the three studied regions concludes that all three provinces lacked availability and access to drug treatment. The main reason is that funding for drug addiction is not prioritized in Afghanistan. The *Afghanistan National Health Account* (NHA) states that only 4 percent of the government budget goes to health services and, of those total expenditures, only 5% goes toward preventative and public health services, including drug treatment.⁶⁷ The report acknowledges these deficiencies and states that the government is reliant on donors and future outcomes are dependent on international support. With such a large portion of foreign aid, the following questions should be asked in regards to sustainability and selectivity: How are resources allocated and chosen? Have donors been able to make a stronger push in provinces that they perceive as most important?

While there are no direct answers, it seems that funds are distributed to populated provinces that are perceived to have the most “at risk” drug users, since the areas with most drug treatment capacity are: involved in the drug trade, have high population density from intense migration, are near drug trafficking routes, and/or have suffered from conflict. At the moment, there are 12 provinces that do not have drug rehabilitation services for their residents.⁶⁸ As far as donor support, research suggests that the international communication has influenced central government’s decisions; however, how much and their role in implementing provincial programs is debatable. This can be seen with Southern Afghanistan, which receives the highest support (besides the nation’s capital region) and is of great interest to the international community.

When ranking each province for availability and access to drug treatment, Kabul has medium capacity, while Kandahar and Badakhshan have low/medium capacity. In 2009, the Ministry of Public Health (MOPH) put together Table 6, which lists active health care facilities in each province that residents can use when needing medical

⁶⁷ Islamic Republic of Afghanistan MOPH, *Afghanistan National Health Accounts 2008–2009* (Kabul: USAID, 2011), 17.

⁶⁸ Rainer Gonzalez Palau, “Drug Abuse and Treatment Facilities in Afghanistan,” *Civil-Military Fusion Centre: Afghanistan in Transition* (2012): 3.

assistance. The study found that Kabul had 137 centers, Kandahar had 43 centers, and Badakhshan had 79 centers. While the amount of facilities looks adequate for a developing post-conflict province, the services provided in mobile clinics, basic health care, and sub health centers are minimal and standards are considered below par. Most health workers are not trained in mental illness or drug addiction. Even though Kandahar has less health facilities than Badakhshan in the table below, it has more comprehensive health centers available to its citizens. These health facilities are able to provide more advanced treatment for addicts than the basic health care and sub health centers.

Table 6. List of Active Health Facilities by Province in 2009⁶⁹

	Special Hospital	Regional Hospital	Provincial Hospital	District Hospital	Comprehensive Health Center	Basic Health Care	Sub Health Center	Mobile Clinic	Other	Total
Kabul	20			6	36	60	2	3	10	137
Kandahar		1		1	16	16	1	2	6	43
Badakhshan			1	1	13	35	21	4	4	79

While all three provinces have some sort of specialization, they are also known to have low bed occupancy rates which mean difficulty accessing drug treatment services. One treatment program in Kandahar reportedly had 1,133 addicts on its waiting list.⁷⁰ A WHO report confirms the need for more resources; the estimate states that 20 percent of Afghan addicts need residential inpatient treatment yet current infrastructures allows only 2 percent to have access.⁷¹ Gaining access to Basic Package of Health Services (BPHS) is furthermore taxing in rural areas, where service times are limited. Many Afghans are “forced to seek treatment at BPHS facilities either “after hours” (at higher costs) or as NHA findings seem to indicate, private facilities which are traditionally more expensive.”

⁶⁹ Islamic Republic of Afghanistan MOPH, “List of Active Health Facilities by Province in 2009,” last modified April 13, 2009, <http://www.moph.gov.af/>.

⁷⁰ Relief Web, “Afghanistan: Despite Counter-Narcotics Efforts, Number of Drug Addicts still High in Kandahar,” last modified June 27, 2012, <http://reliefweb.int/report/afghanistan/despite-counter-narcotics-efforts-number-drug-addicts-still-high-kandahar>.

⁷¹ Islamic Republic of Afghanistan Ministry of Counter Narcotics, *National Drug Demand Reduction Policy 2012–2016* (Kabul: Islamic Republic of Afghanistan MCN, 2012), 13.

Kabul ranked higher than Kandahar and Badakhshan because it has significantly more drug treatment services and has a more advanced 24-hour detoxification hospital, which was opened by the International Medical Corps and the MOPH in January 2011. It serves as the “only public national referral mental health hospital and drug abuse center for all of Afghanistan, while also serving the needs of all psychiatric patients in Kabul.”⁷² While this hospital sounds impressive, the Canadian Women for Women organization noted that the program has multiple administration and quality-control concerns. Their report described its weaknesses: “The hospital, long notorious for its dilapidated and unhygienic state, has only 60 beds; while experts say at least a 300-bed facility is needed...[it] remains the only mental health hospital in the country, despite announcements by the Ministry of Public Health (MOPH) back in 2006 that 30-bed mental health hospitals would be open in every region of the country.”⁷³ Dr. Hamid Folad⁷⁴ of the MOPH stated in an interview / e-mail that “Kandahar and Badakhshan recently opened up detoxification hospitals and that Kandahar had both day and night time IDP services available.” He further said that psycho social and drug addiction treatment capabilities exist in both these detoxification hospitals. While the MOPH is moving in a positive direction, research suggests that these centers are still weak because they are newly developed, lack expertise, and have limited capacity.

2. Component #2: Screening, Assessment, Diagnosis, and Treatment Planning

In terms of provincial human capital for screening, assessment, diagnosis, and treatment planning, I conclude that Kabul has medium capacity, Kandahar has low/medium capacity, and Badakhshan has low capacity. Afghanistan lacks quality interventions for addicts because there are not many skilled professionals that know how to adequately screen, assess, diagnose, and treat a patient. Currently, evidence-based research is completed through the psychology department in Kabul University.

⁷² International Medical Corps, “Afghanistan: Mental Health and Substance Misuse,” last modified 2012, <http://internationalmedicalcorps.org/page.aspx?pid=2273>

⁷³ Canadian Women for Women in Afghanistan, “Women & Mental Health in Afghanistan,” last modified February 23, 2011, <http://www.cw4wafghan.ca/MentalHealth>.

⁷⁴ Dr. Hamid Folad is the Deputy Program Manager for DDR Program at the MOPH

According to its website, there are approximately sixty students being taught the necessary skills. Once students are finished with their education, they can “work as educational manager of higher education, lecturers in teacher’s educational institutes, advisers in psychology, senior advisors of schools, education inspectors and employees of the women and social affairs ministries.”⁷⁵ Although this university has a mental health department, it only supports a small number of students. As mentioned in the first component, Afghanistan has only one detoxification hospital that is capable of supporting addicts with psychological co-morbidity disorders. Considering the number of individuals suffering from PTSD and other conflict-related mental illnesses, the absence of a national mental health program is discouraging. If Afghan addicts were able to manage additional mental health issues, it would decrease triggers and make quitting more manageable. This is the primary reason why Kabul did not receive medium/high status.

One of the main challenges for provinces outside of Kabul is recruiting educated locals to do counseling. “Most psychologists do not want to go to insecure areas like Kandahar, Helmand, and Khost provinces.” says Dr. Hamid Folad.⁷⁶ Since there is such a demand for drug counseling, program directors have had to rely on short courses for their staff. These trainings are being done in Kandahar and Badakhshan by agencies such as the UNODC and the Colombo Plan. While it is great that Afghanistan has implemented a localized approach, doing short courses is only a temporary solution. Having educated influential leaders in rural provinces increases the likelihood that interventions are more advanced, drug prevention/awareness education is prioritized, and provincial barriers that hinder cooperation between the MOPH and the Ministry of Counter Narcotics (MCN) are better understood by policy makers.

The reason why Kandahar scored slightly higher than Badakhshan was because it was seen as more interactive in its recruitment of health workers. Kandahar province has been able to use its tribal leaders to recruit community volunteers and to increase drug awareness. For example, the Drug Demand Program (DDR) organized a two-day workshop in 2000 that included a wide variety of community leaders. Of the 70

⁷⁵ Kabul University, “Psychology,” ND, <http://ku.edu.af/en/page/884>

⁷⁶ Dr. Hamid Folad is the Deputy Program Manager for DDR Program at the MOPH

individuals that were invited, there were “religious scholars, shura members, teachers, tribal elders, resource persons, influential people and farmers [who were all trained] on the harmful effects of drugs on health, education, society, economy and ethic of people.”⁷⁷ Including more groups increases awareness in the community and instills a more community-based approach.

Even though skill levels vary in each province, the MOPH has been proactive in creating a professional package for psychosocial counselors. They can use this tool when assessing and screening patients. It was written in 2008 and made available in English, Dari, and Pashto. The professional package has two sections: counseling skills and psychopathology.⁷⁸ The first section outlines intervention techniques and provides a list of outside resources that improve addict’s likelihood of quitting. The second section describes warning signs of common mental disorders and gives recommendations on how to support patients who are experiencing symptoms. In the substance abuse and dependence chapter, it suggests that counselors explore: withdrawal symptoms and their severity, mode and frequency of use, psychosocial stressors, and impacts on patient’s daily routine.⁷⁹ All of these indicators are important when creating an individual treatment plan. It additionally recommends referring a patient to a rehabilitation clinic if they experience one of the following: “withdrawal symptoms are severe, there is a suicide attempt or risk of suicide, there is a possible associated physical illness, initial counseling was not effective, mental disorder is present, [or] use of traditional remedies.”⁸⁰ While the MOPH has developed resources for counselors, one must question how likely are these professional packages used? Are they in all medical centers and drug treatment clinics? Does availability effect how doctors and counselors screen? Are counselors following the list of symptoms or just recommending the most severe patients?

77 Relief Web, “Afghanistan Weekly Update No. 383,” 1.

78 Islamic Republic of Afghanistan MOPH, *Professional Package for Psychosocial Counselors Working in the BPHS in Afghanistan* (Kabul: Mental Health Department of the MOPH, 2008), table of contents.

79 Islamic Republic of Afghanistan MOPH, *Professional Package*, 81.

80 Islamic Republic of Afghanistan MOPH, *Professional Package*, 81.

3. Component #3: Evidence-Informed Treatment

Some evidence-based research has been conducted in Afghanistan on drug demand and harm reduction services; however, it is limited and mostly focuses on decreasing addiction to prevent outbreaks of HIV/AIDS. Usually scientific methods are first tested in Kabul, since it is the most convenient location, and then implemented in other provinces if the project is successful. The most scientific ones began in 2005 by Catherine Todd, an Associate Research Scientist at Columbia University's Department of Obstetrics and Gynecology; her studies in Afghanistan primarily focus on IDUs in Kabul. Her research has stated that there are a lack of resources and education in regards to harm reduction services. She additionally explores the most common reasons for drug use and states that refugees are at greatest risk, because they are the most vulnerable to socio-economic conditions and most likely to experience psychological trauma which can lead to more risky behaviors⁸¹. More evidence-based research and resources needs to be constructed in Afghanistan to ensure a more unified health care system is built. Technological approaches, like geographic information system (GIS) mapping and rapid situation assessments, can further enhance and extend research projects.⁸² Examples of topics to study are: evaluating social-economic impacts of drug use, examining how culture impacts interventions, and assessing community referral systems.

Evaluating evidence-informed research in each province, Kabul has medium capacity while Kandahar and Badakhshan have low capacity. Kandahar and Badakhshan are equal in capabilities for the reason that there have only been a handful of drug addiction studies done in these provinces. The reason why Kabul did not receive higher capacity in evidence-informed treatment is, because policy makers and the MCN have not permitted citizens to use Opium Substitution Therapy (OST)—such as methadone treatment. In Afghanistan, detoxification is the primary method used in drug treatment facilities; this method is known to be less effective and has high relapse rates of

81 Catherine Todd, Naquibullah Safi, and Steffanie Strathdee, "Drug Use and Harm Reduction in Afghanistan," *Harm Reduction Journal* 2. no. 13 (2005): 4.

82 UNODC, *Reducing Drug Demand and HIV in Afghanistan, Time Frame: June 2010 – July 2012*, (UNODC, 2010), 5.

approximately 92%.⁸³ OST has been studied for over 20 years; research has proven that it is ultimate mechanism for “addressing chronic and repeated relapsing opiate dependency.”⁸⁴ It additionally can be used to improve socio economic conditions, such as crimes and HIV rates. According to one progress report, data suggest that only 0.04 percent of addicts can access methadone.⁸⁵ Those who have access to methadone in Afghanistan are getting it from foreign non-governmental organizations (NGOs) in Kabul, who are not aligned with the MOPH and MCN.

To give some background on the OST controversy, it would be best to explain the roles of the MCN and the MOPH. The MCN is responsible for guiding drug policy while the MOPH is accountable for project implementation in the community. While these organizations work collaboratively, their responsibilities oftentimes mesh and result in miscommunications. For example, arguments arise when discussing harm reduction approaches. The MCN see methods like OST as a culturally sensitive issue and it demands a more conservative approach. It would prefer to remain abstinence-focused to ensure programs meet the overarching goal of reducing illicit substances within the community. The MOPH disagrees and favors harm reduction methods, like OST, for the reason that it has been proven to be more successful in curbing addiction, minimizing social problems within the community, and deterring outbreaks and other health related issues from occurring.

Even though there is still controversy between the two groups, the MOPH and the UNODC have moved forward and created a pilot methadone project for 100 Kabul patients. They cannot start the project until the memorandum of understanding is approved by the MCN. This is not the first time the MOPH has tried to pass a pilot project. The MCN has taken action against the new policy by “block[ing] the import of

⁸³ Pavol Stracansky, “Afghanistan: New Therapy Battles Soaring Drug Addiction,” *Inter Press Service News Agency*, April 5, 2011, 1.

⁸⁴ Islamic Republic of Afghanistan MOPH, *Final: Policy on Opioid Substitution Therapy* (Kabul: Islamic Republic of Afghanistan MOPH, 2009), 8

⁸⁵ WHO, UNAIDS, and UNICEF, *Global HIV/AIDS Response: Epidemic Update and Health Sector Progress towards Universal Access* (Geneva: WHO, 2011), 130.

methadone” twice⁸⁶ and stopping the initial OST trial to re-examine results.⁸⁷ Past incidents suggest that the implementation process will probably be lengthy. Even if the pilot program is successful in Kabul, it is unlikely that OST will be socially accepted in Badakhshan or Kandahar. These regions are known to be more conservative and distrustful of international donors; thus there is a high likelihood that tribal leaders will see methadone treatment as unethical. In addition, it is difficult to integrate new approaches in rural regions. Economic implications, low literacy rates, and vast population clusters would further complicate Badakhshan and Kandahar’s ability to reach vulnerable groups. If the MCN approves the trial, the MOPH will need to create a comprehensive OST awareness campaign that is informative as well as culturally acceptable for outside provinces.

4. Component #4: Human Rights and Patient Dignity

When examining human rights and patient dignity, Kabul has medium/high capacity, Kandahar has low capacity, and Badakhshan has low/medium capacity. Kabul scored higher because it built the institutional framework for human rights and has developed future objectives for drug experts and law enforcement personnel.⁸⁸ It did not receive high capacity status, because it still struggles with enforcing human rights policies.⁸⁹ According to one survey, over half of Afghan women addicts reported “at least one form of human rights violations prior to entering the [drug abuse treatment] DAT centers.”⁹⁰ In the future, the MOPH hopes to partner the Independent Human Rights Commission of Afghanistan to improve discrimination for vulnerable addicts by:

⁸⁶ Rubin, “Few Treatment Options for Afghans as Drug Use Rises,” 1.

⁸⁷ Stracansky, “Afghanistan: New Therapy Battles,” 1.

⁸⁸ The Afghan constitution specifically states that it “prohibits any kind of discrimination against Afghan citizens...NSF-II and HIV policy mentioned that all Afghan have equal right to access to preventive, treatment and support services free of any kind of discrimination.”; Islamic Republic of Afghanistan MOPH, *Director General of Preventative and Primary Health Care Communicable Disease Directorate* (Kabul: Islamic Republic of Afghanistan MOPH, 2012), 37.

⁸⁹ While the Ministry of Justice has taken action and enforced these new policies, their implementation is perceived to be relatively poor; Islamic Republic of Afghanistan MOPH, *Director General of Preventative*, 37.

⁹⁰ 35% reported gender-based inequality, 36% reported maltreatment, and 4% reported abuse; Abadi, Melissa Harris et al., “Examining Human Rights and Mental Health Among Women in Drug Abuse Treatment Centers in Afghanistan,” *International Journal of Women’s Health* (2012), 160.

providing substance abuse education, defending drug user's legal rights, and introducing programs that will help the community better understand addiction and the stigma associated with it.⁹¹

Managing sensitivities on drug dependency are influential in increasing success rates; addicts will feel less depressed and pressured if they feel they are accepted in their community. Bad perceptions also make recruitment more difficult; addicts will not seek residential treatment if it means that they will lose family ties or clan networks. A 2012 study surveyed perceptions in Kabul and found that most “participants agreed that addiction is a disease (88.6%)” and supported drug treatment programs in Afghanistan.⁹² While this rate is impressive, Kabul residents still struggle to accept harm reduction programs.⁹³ To manage stigmatization and ensure confidentiality in interventions, all three of the case studies offer at-home treatment. The survey recommends that, in the future, Kabul focus on prejudices from medical staff, police officers, pharmacists, and influential groups. There currently are no surveys in Kandahar and Badakhshan on drug abuse perceptions; nonetheless, results are expected to be worse since they have less drug counseling and educational/awareness programs.

Kandahar and Badakhshan received lower scores, because stigmatization was reported heavily in these provinces. Discriminatory beliefs have limited participation in drug programs as well as kept awareness campaigns from being introduced into the community. Past studies have found that tribal leaders and mullahs are resistant to provide information about high-risk group activities in their area mostly for fear that neighborhoods or individuals could be targeted.⁹⁴ Research suggests that this would be more prevalent in Southern Afghanistan because it is more conflicted. In Kandahar, many

⁹¹ Islamic Republic of Afghanistan Ministry of Counter Narcotics, *National Drug Demand Reduction Policy 2012–2016*, 22.

⁹² MR Stanekzai et al., “Baseline Assessment of Community Knowledge and Attitudes toward Drug Use and Harm Reduction in Kabul, Afghanistan,” *Drug Alcohol Review* (2012): 451.

⁹³ While they are sympathetic towards the challenges of drug dependency, only four percent of residents in the Kabul survey felt it was okay to provide harm reduction services; Stanekzai et al., “Baseline Assessment,” 455.

⁹⁴ South Asia Human Development Sector, *Mapping and Situation Assessment of Key Populations at High Risk of HIV in Three Cities of Afghanistan* (The World Bank, 2008), 6.

prefer home based treatment because they are afraid of the stigma associated with being a drug user.⁹⁵ Badakhshan women have expressed similar fears when seeking assistance; they worry that they will lose their child if they seek help. “Female drug users is a topic that is almost never mentioned,” says Ferris-Rotman.⁹⁶ While both provinces struggle with similar issues, Kandahar’s challenges are seen as slightly more severe, because tribal networks intensify negative perceptions in the community. When tribal leaders have too much political influence, it becomes difficult to ensure equal rights within social services. In the past, Kandahar citizens reported difficulty accessing social services (e.g., housing, employment, and land ownership) if they were aligned with the wrong tribe or if they broke clan ideals/rules.⁹⁷

To improve communication between central and provincial governments, organizations have begun to include local leaders into harm reduction trainings so that each province can create a more individualized approach when tackling human rights issues.⁹⁸ They have additionally tried to include women leaders in hopes that it will improve awareness and community acceptance. Confidentiality has been reinforced through all research studies, trainings, and drug rehabilitation centers. The Colombo Plan is currently collaborating with Afghanistan trainers to draft a code of ethics for the country. Once it is approved by authorities, 500 staff members will be trained and given the code of ethics to use as a “standard of conduct.”⁹⁹

5. Component #5: Targeting Special Groups and Conditions

The literature review and the UNODC recommend the following special groups be targeted when developing drug treatment programs: pharmaceutical users, refugees,

95 United Nations Assistance Mission in Afghanistan, “Featured News: Despite Counter-Narcotics Efforts, Number of Drug Addicts Still High in Kandahar,” last modified June 27, 2012, <http://mpwiis07-beta02.dfs.un.org/Default.aspx?tabid=1783&ctl=Details&mid=1882&ItemID=17171>.

96 Amie Ferris-Rotman, “Lifting the Veil Off Afghanistan’s Female Addicts,” *FirstPost World*, April 1, 2012, 1.

97 Carl Forsberg, *Politics and Power in Kandahar* (Washington, DC: Institute for the Study of War, 2010), 11.

98 South Asia Human Development Sector, *Mapping and Situation Assessment*, 6.

99 Brian Howtay, “2nd Training of Afghan Trainers on Ethics for Addiction Professionals,” *The Colombo Plan*, May 31, 2012, 1.

patients with co-morbidities, HIV/AIDS patients the mentally ill, women and children, prisoners, and police officers. The degree to which special groups are targeted varies from province to province. After assessing each region's ability to assist specialized groups, my research suggests that Kabul has medium/high capacity, Kandahar has medium capacity, and Badakhshan has low/medium capacity. While all three provinces target a variety of programs, none of them had high availability and access to treatment, which would have put them at high capacity status.

a. Pharmaceutical Users

While high addiction rates are mostly attributed to Afghanistan's harsh environment, it should be noted that Afghan's decision to rely and consume a variety of illicit and licit drugs is ingrained in their culture. Historical tales have increased the discovery of newly emerging drugs as well as created a false illusion on the feeling of being high.¹⁰⁰ In addition, these stories have rationalized the use of prescription drugs as an emotional and physical crutch. Many chose opium, because it is less costly, being unaware that the high potency would make them drug dependent.

There are also reports that pharmaceutical drugs are not being administered correctly. If patients want a specific prescription, they will oftentimes request it through private pharmacies or pay a marked up rate through illegitimate channels. As Macdonald notes, "a wide range of pharmaceutical drugs is available over-the-counter, without a medical prescription, from 'pharmacies', other retail outlets and even roadside stalls. Many of these drugs are adulterated, spurious, outdated, and unregistered and illicitly manufactured in Pakistan and India."¹⁰¹ Mixed drug use could possibly increase the likelihood of severe mental or physical side effects within the Afghan population. These statistics are disturbing because they show the potential for a health crisis as well as the severity addiction could have on the next generation if they

¹⁰⁰ There are many historical tales that are told in Afghanistan that describe the sensational feeling of being intoxicated. For example, there is talk that individuals dry, crush, and smoke scorpions for intoxication; David Macdonald, *Drug Use in Afghanistan: Opium, Outlaws, and Scorpion Tales* (London: Pluto Press, 2007), xix.

¹⁰¹ David Macdonald, "Drug Use in Afghanistan: Opium, Outlaws," 208.

continue to use legal and illegal drugs as an emotional crutch. In fact, pharmaceutical use is heavily linked to poverty. Health costs constitute the second-largest expenditure for Afghan families; it is common to go into debt to pay for medical expenses and prescriptions.¹⁰²

Kabul is the only location that has done studies on pharmaceutical misuse; the province is seen as more progressive, because it has advanced educational awareness campaigns and has more quality mental health interventions. Policy makers in Kabul have additionally advocated the promotion of rational medicine consumption. While there is a policy set up to improve pharmaceutical care, it still needs to be enforced nationally to be taken seriously. U.S. Agency for International Development (USAID) states that there are, “poor dispensing practices and record keeping, insufficient knowledge of medicines listed in Afghanistan Essential Drug List and Licensed Drug List, weak communication with patients concerning their medications, and avoidance of dialogue with doctors to clarify prescriptions.”¹⁰³ Since Kandahar and Badakhshan are closely aligned to tribal networks, have a traditional approach, and expressed difficulty in accessing health care, they are more likely to have a higher degree of pharmaceutical misuse. Accessing medications is especially concerning for more impoverished and rural areas like Badakhshan, where they cannot afford health care. Grace and Pain suggest that central government focus on transparency of the health system by, “closely control[ling] pharmaceuticals and pharmacies to prevent the sale of ineffective medicines and ensure that drugs and antibiotics are only available by prescription.”¹⁰⁴ In addition, Afghanistan needs to improve economic markets and control medicine costs to ensure that residents can afford the medications.

102 Jo Grace and Adam Pain, *Rethinking Rural Livelihoods in Afghanistan* (Kabul: Afghan Research and Evaluation Unit, 2004), 51–52.

103 USAID, “Snapshot: Dispensing Good Medication Practice,” last modified 2011, http://afghanistan.usaid.gov/en/USAID/Article/2292/Dispensing_Good_Medication_Practice

104 Grace and Pain, *Rethinking Rural Livelihoods in Afghanistan*, 2.

b. Refugees

Most of the research on refugees has been conducted in Kabul. In Todd's opinion, prioritizing refugees will yield positive results because they are more susceptible to addiction and have less knowledge regarding the impacts of risky behaviors.¹⁰⁵ Refugees are often linked to other high-risk groups (e.g., as: sex workers, prisoners, homeless, and mentally ill) because of their harsh living conditions. To give some background, there was a large refugee population that migrated back to Afghanistan after the fall of the Taliban. Both Kabul and Kandahar were affected by this rapid migration.¹⁰⁶ Kabul experienced the greatest surge in Afghanistan, because of the steady movement of Pakistan and Iranian individuals who returned to the capital in search of a better livelihood. Since these two countries have high addictions rates and harsh conditions, many of the refugees came back addicted to a wide variety of substances. In the past, severe heroin addicts could be found at the Russian cultural center. Due to strong police enforcement, Kabul addicts have moved to the "Pul-i-sokhta" bridge and are found in small groups, hunched over sheets of foil, heating up opium.¹⁰⁷ The winter seasons are the worst in Kabul, because severe weather conditions cause addicts to increase their intake and overdose.

To improve the situation, the MOPH enriched its refugee program by partnering with donors to understanding the daily ramifications that migrants encounter. These studies found that a large percentage of refugees in Kabul were unemployed¹⁰⁸ and expressed difficulty in accessing health services, housing, nutritious food, and sanitized

105 Todd, Naquibullah, and Strathdee, "Drug Use and Harm Reduction in Afghanistan," 4–6.

106 "About a third of the returning refugees went to the eastern provinces of Kabul and Nangarhar, with about 11 per cent heading to Kunduz province in the north. The other most popular destinations were Herat, Baghlan, Kunar, Kandahar, Paktya, Balkh, Logar and Laghman provinces."; UNHCR, "Afghan Returns Pass 50,000 in First Eight Months, Up on Last Year," *The UN Refugee Agency website*, last modified August 30, 2012, 1.

107 Alissa J. Rubin, "Few Treatment Options for Afghans as Drug Use Rises," 1

108 Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs* (Kabul: Islamic Republic of Afghanistan Ministry of Economy and World Bank, 2011), 28.

drinking water.¹⁰⁹ The Janglaka Drug Treatment Center was first established in Kabul to assist addicts living in the Old Russian Cultural Center.¹¹⁰ While the center's primary purpose is detox, it also has out-patient and reintegration services, such as, vocational training, family therapy, primary healthcare referrals for patients, and harm reduction services. Although referral systems remain weak throughout the province, the ministries have received international funds to target new communities, like the "Pul-i-sokhta" bridge, that have the most severe addiction cases. Welfare programs which have been put in place by donors and the ministries have already begun to see results.¹¹¹ The challenge is that while there have been success stories in certain regions, there remains a large percentage of refugees who cannot access services to ensure their quitting drugs is successful. For example, the Janglaka Drug Treatment Center can only hold forty residents at one time, which means extremely long waiting lists.

My research suggests that refugee programs are somewhat absent in both Kandahar and Badakhshan. This does not mean that refugees are not targeted in drug treatment programs. Both provinces mentioned that they try to educate and provide harm reduction services to assist risky populations, which includes refugees. While this cannot be confirmed, there is a good chance that Kandahar's tribal hospital, which assists IDPs, has simultaneously assisted refugees. To fully understand how refugees are managed in Kandahar and Badakhshan, further research would need to be conducted.

109 Erin Grinnell and Troc Heloise, *Kabul Vulnerability Mapping* (Afghanistan: Action Contre La Faim, 2004), 3; UNHCR, "Conflict- Induced Internally Displaced Persons in Afghanistan." *Internal Displacement Monitoring Centre website*, last modified July 2012, [http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/81604190AD126D11C125785200620C06?OpenDocument](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/81604190AD126D11C125785200620C06?OpenDocument).

110 WADAN, "Drug Control: Jangalak Drug Treatment and Rehabilitation Center in Kabul City," ND, <http://www.wadan.org/drug.asp?CatID=9&ContID=101>.

111 Kabul residents have reported a significant increase in living conditions and access to food. When surveying households in Kabul to see if they have problems satisfying their food needs during the year, results showed that 57% never had problems, 20% rarely (1–3 times per year) had problems, 20% sometimes (3–6 times per year) had problems, and 2% often (few times a month) had problems, and 1% mostly (happens a lot) had problems; The World Food Programme, "Provincial Profiles," last modified 2007, <http://www.foodsecurityatlas.org/afg/country/provincial-Profile>

c. Patients with Multiple Illnesses

Managing co-morbidities is a national concern that has not been addressed; this is another explanation to why all three provinces did not receive a higher status in regards to targeting population groups. A patient is diagnosed with co-morbidities when they have two or more physical or mental illnesses. Providing resources for co-morbidity disorders is important, because less physical and mental urges impacts success rates. If addicts need assistance with physical illnesses, they can contact a local health care center; however if mental support is requested, they have to travel to the Kabul hospital. While rehabilitation clinics see the need to connect health services to drug counseling, most do not have the capacity to do so because they do not have the trained staff. To manage inefficiencies, the MOPH has created specialized trainings as well as a counseling package (mentioned in component 2) to increase personnel's confidence in screening, diagnosing, assessing, and developing a treatment plan. While most health centers are weak, the detoxification hospitals have specialized services as well as nutritional care. All of these health services are free if they access them through BPHS; however most prefer going to private hospitals since they are superior and can give a more accurate diagnosis.

d. HIV/AIDS Patients

Kabul, Kandahar, and Badakhshan all target HIV/AIDS patients. Resources are much richer, because of the socio-economic concern an outbreak could have worldwide. Most of the services given to residents are through harm reduction programs which include: pamphlets, free condoms, counseling, needle syringe program, healthcare, HIV testing, and other services. While there are funds given to combat the disease, there are only two anti-retroviral treatment (ART) services in Kabul and Herat that have the capacity to support HIV/AIDS patients. On a national level, the HIV/AIDS program is still considered limited because of: "irregular drug supply, low ART coverage, drug resistance, low capacity for service delivery, lack of psycho-social support and drop

out.”¹¹² At the moment, only 20% of IDUs are covered which a comprehensive package of resources.¹¹³ Currently in Afghanistan, there are “1.1 needle and syringe programs sites per 1000 people who inject drugs.”¹¹⁴

While all three provinces were proficient in handing out harm reduction services, they struggled to provide education simultaneously. Intermedia’s national study on HIV/AIDS awareness and found that “only one percent [of participants] were able to respond correctly to seven true/false statements about the disease.”¹¹⁵ A Johns Hopkins study found similar results when asking participants where they received their HIV/AIDS knowledge. Results indicated that 43% knew of HIV/AIDS through the media, 57% through friends and doctors, and 0.5% knew through harm reduction services.¹¹⁶ The study further recommended prioritizing prevention methods. Only 9% of the individual surveyed in Kabul, Mazar, and Herat were aware of the benefits of using condoms consistently.¹¹⁷ This result was surprising since even Kabul, with its more advanced resources and programs, still struggles to provide preventative education to addicts. The good news is that the Johns Hopkins study benefited IDUs who participated in the study. If a participant tested positive for HIV in Kabul, Mazar, and Herat, he was referred to the WHO in Kabul to get treatment. Currently, Badakhshan and Kandahar do not have this type of program.

e. Mental Health

To assist citizens who have undergone war-related violence and experienced the effects of PTSD, the Afghanistan government announced in 2003 that it

112 National AIDS Control Program, Ministry of Public Health, *2010 National Composite Policy Index (NCPI) Report: Afghanistan* (Kabul: UNAIDS, 2010), 1–42.

113 International donors feel that coverage should be at 60% to prevent HIV transmission.; UNODC, *Reducing Drug Demand and HIV in Afghanistan*, 2.

114 WHO, UNAIDS, and UNICEF, *Global HIV/AIDS Response*, 130

115 Haleh Vaziri and Sonja Gloeckle, *HIV and AIDS Awareness and Knowledge in Afghanistan* (Washington, DC: InterMedia, 2008), 6.

116 John Hopkins surveyed IDUs, prisoners, transport workers, and female sex workers in Kabul, Mazar, and Herat; National AIDS Control Program (NACP), *Integrated Behavioral and Biological Surveillance (IBBS) in Afghanistan: Year 1* (Kabul: MOPH, 2010), 14

117 National AIDS Control Program (NACP), *Integrated Behavioral and Biological Surveillance*, 15.

would rebuild its national health system. It determined that mental health and disability were two of seven crucial initiatives that needed to be implemented in the Basic Package of Health Services (BPHS) that are given to Afghanistan residents. The others 5 priorities mentioned were: maternal and newborn health, child health and immunization, public nutrition, communicable diseases, and supply of essential drugs.¹¹⁸ The report moreover stated that mental health and disability were “second tier” and would be “phased in at a later date.”¹¹⁹ Mental health was included in the BPHS two years later, but the new programs were unreachable to the public. For example, the WHO estimated 11 outpatient mental health facilities in Afghanistan in 2006.¹²⁰ Due to unclear guidelines, the BPHS was revised in 2009 in hopes that structural changes would improve the quality of treatment. While increased policy initiatives have enhanced Afghanistan’s mental health programs, there are still three weaknesses that must be addressed: BPHS strategies are not being executed in rural regions, the national system does not have standard reporting tool, and mental health centers need to be better connected to the ministries.

My case study research indicates that Kabul is the strongest performer on this dimension because it has more resources and the only psychiatric hospital in the country. While Kabul is stronger than the other two provinces studied, it should be noted that it is weak when compared to other countries. The hospital has “three dozen psychiatrists and psychologists [and they] see as many as 160 patients a day at the crumbling 26-year-old facility that they are still rebuilding after a bomb six months ago.”¹²¹ Along with hospital services, Kabul residents had access to Nejat, a non-governmental organization that specializes in assisting Afghan refugees who have experienced psychological trauma from war and social dislocation.¹²² Even though

118 Transitional Islamic Government of Afghanistan Ministry of Health, *A Basic Package of Health Services for Afghanistan* (Kabul: MOPH, 2010), 6–7.

119 Transitional Islamic Government of Afghanistan Ministry of Health, *A Basic Package*, 9.

120 WHO-AIMS, *Mental Health System in Afghanistan* (Kabul: WHO and MOPH, 2006), 6.

121 M. Hennessy-Fiske, “Tackling Mental Health Problems in Afghanistan,” *Los Angeles Times*, May 15, 2011, 1.

122 Wayne Bazant, *Emerging Practices for the Treatment and Prevention of Drug Dependence in Afghanistan: Integrated Drug Prevention, Treatment and Rehabilitation Project in Afghanistan* (Afghanistan: GTZ International Services, 2006), 2.

mental health capacity in Kandahar and Badakhshan is unknown; it is clear that there are services available and referral options for addicts. The BPHS clearly outlines requirements of health posts, health sub-centers, mobile health teams, basic health centers, comprehensive health centers, and district hospitals. The list states that all health facilities must provide: mental health awareness, identification of suspected cases, community based rehabilitation, and monitoring and follow-up.¹²³ While these services are available, there are questions regarding the quality of intervention and ability to create a specialized treatment plan for mental health patients.

Another social barrier in Afghanistan is that residents cannot afford psychotropic medicines that would improve their physical and emotional wellbeing. One report states that access to free medication is extremely limited (less than 1%); those that get medicine end up paying approximately 12–16 percent of their daily wage.¹²⁴ Current documents from the case study additionally showed that there is still a shortage of psychologists and psychiatrists in all three provinces despite the alarmingly high rates of individuals suffering from PTSD.¹²⁵ A lack of skilled mental health professionals is troubling, because Kabul and Kandahar have extremely high rates of war-related trauma and/or domestic violence.¹²⁶ Provinces with high domestic violence are usually in areas which either are influenced by the Taliban (e.g., Kandahar) or in regions that have inadequate court systems to stop the oppression of women. By 2014, the MOPH hopes to “increase BPHS based mental health service by 75% from 2009 levels” and create a program which they can monitor from the provincial level.¹²⁷ To build capacity, the MOPH states that it will do the following: expand referrals systems, provide mental

123 Transitional Islamic Government of Afghanistan Ministry of Health, *A Basic Package*, 24.

124 WHO-AIMS, “Mental Health System in Afghanistan,” 4.

125 “Afghanistan has substantially fewer psychiatrists, psychologists, and psychiatric nurses per 100,000 residents than in neighboring countries such as Pakistan and Iran,” Beryl Lieff Benderly, “Rebuilding Afghanistan’s Mental Health System,” *SAMHSA News* 14, no. 1, 3.

126 One study found that 79.3 percent of individuals experienced some type of domestic violence (whether physical, psychological, sexual, or forced marriage) in Kabul, 92.4 percent in Kandahar, and 53.9 percent in Badakhshan; Diya Nijhowne and Lauryn Oates, *Living with Violence: A National Report on Domestic Abuse in Afghanistan* (Washington, DC: Global Rights, 2008), 21.

127 Mental Health & DDR Department, MOPH, *National Mental Health Strategy 2009–2014* (Kabul: Islamic Republic of Afghanistan MOPH), 24.

health education in communities, construct functional mental health units in all provinces, refine legislation, and improve skill in the workforce.

f. Women and Children

While Badakhshan is seen as the weakest of the three provinces, it is currently one of six provinces that offer inpatient services for women and children. The others being Nangahar, Herat, Feraf, Kabul, and Balkh.¹²⁸ These inpatient treatment clinics have yielded positive results for severely drug dependent mothers, who cannot afford to leave their children in daycare or with families for an extended period of time. The Bureau of International Narcotics and Law Enforcement Affairs (INL), which is located in Kabul, has expanded this concept one step further and incorporated family based treatment. This has improved rates of quitting because addicts have more family support and do not have to return home to a spouse who is using illicit drugs.¹²⁹ If women or children desire in-patient treatment in Kandahar, they must pay high costs to travel to another province. Unfortunately, Afghanistan does not have enough allocated funds to target some of the more rural areas, nor have solutions to managing poor health care and poverty in the region.

As far as out-patient treatment, all three case studies have options for women. Kandahar has nothing for children, which is unfortunate since Southern Afghanistan is known to have a young drug population. Kabul and Kandahar do have childcare services available for women who are interested in quitting through out-patient treatment. The MOPH is currently working on setting up a similar program in Badakhshan. In addition to family services, INL has developed a study which tested the effects of second hand smoke in Kabul, Badakhshan, and Nangahar. It found that “Of the 25 smoking homes, all but two had at least one resident’s hair test positive for opiates. Synthetic opiates (hydrocodone, hydromorphone, and oxycodone) not routinely seen in

128 U.S. State Department, “State Department on Counternarcotics Programs in Afghanistan,” last modified May 04, 2012, <http://iipdigital.usembassy.gov/st/english/texttrans/2012/05/201205045117.html?CP.rss=true#axzz23wAlKkda>.

129 Aunohita Mojumdar, “In Afghanistan, Drug Rehab for Children,” *The Christian Science Monitor*, July 14, 2010, 1.

hair samples were also detected in samples from six users and one 5-year-old child.”¹³⁰ This study has been useful in understanding the dangers of smoking opium in front of children and is progressive in terms of preventative awareness; however the survey still has one more stage until it is complete.

g. Prisoners

The reason why Kabul and Kandahar were closely ranked on their ability to target populations is because they have similar prison programs in terms of capacity. Providing drug demand and harm reduction services to criminals is important; it decreases addiction rates,¹³¹ reduces small-scale violence, and prevents the spread of emerging diseases. Addiction makes it more challenging for prisoners to reintegrate into the community. Badakhshan’s prison programs are limited to harm reduction, because its facility is much smaller and is not prioritized by the international community.

Kabul’s Drug Demand and Reduction Action Team (DRAT) manage 450 addicts in Pul-e Charki prison and technical staff includes “three social workers, one psychologist, and one psychiatrist.”¹³² The Central Prison Department (CPD) additionally has 3 physicians and 14 staff members that collaborate occasionally with DRAT to improve addiction rates.¹³³ Although Kabul struggles to assist IDUs, it does have a good percentage of welfare services that increases the likelihood of prisoners staying off drugs once they have quit. For example, the Women for Afghan Women (a local NGO) has added a transitional house, named “House of Hope” that gives basic services for females leaving prisons in Kabul.¹³⁴ Having a support group as well as legal aid, vocational

130 Bruce Goldberger, David Martin, and Mark Gold, *Opium Study: The Study of Second and Third-Hand Exposure in Women and Children of Afghanistan* (Folsom: NES, 2011), 5.

131 Study found that “between 30% and 50% of problem drug users in prison started using drugs after they were imprisoned, with reports of IDUs in Herat, Kabul and Mazar prisons;” MOPH and MCN with Ministry of Justice, NGOs, and International Experts, *Conference Report: Conference on Opioid Substitution Therapy: An Essential Service in Harm Reduction in Afghanistan* (Kabul: MOPH, 2008), 4.

132 UNODC, *Afghanistan: Implementing Alternatives to Imprisonment, in line with International Standards and National Legislation* (New York: United Nations, 2008), 59.

133 UNODC, *Afghanistan: Implementing Alternatives to Imprisonment*, 59.

134 UNODC, “UNODC Chief Visits Transition House for Women Leaving Prison in Kabul,” last modified May 30, 2012, <http://www.unodc.org/unodc/en/frontpage/2012/May/unodc-chief-visits-transition-house-for-women-leaving-prison-in-kabul.html>

training, and literacy classes provides an alternative option in dealing with concerns, other than drugs. While Kabul has more after-care programs available for convicts, Kandahar has a stronger clinical hospital in its prison.

Kandahar has approximately 300 addicts and has the second largest correctional facility in Afghanistan. Approximately a third of its inmates have reported substance abuse issues.¹³⁵ The prison clinic was constructed in 2010 and has “two medical doctors, two social workers, and two healthcare workers.”¹³⁶ While the facility’s primary goal is to deliver basic health services, it also offers both treatment interventions and harm reduction services to addicted prisoners. Kandahar’s mix of clinical assistance, harm reduction options, and counseling services is a model that should be incorporated in all provincial prisons. Although the model is strong, there are still specific administration undertakings that must be addressed to ensure sustainability in the future. Even though staff are trained and are able to provide a standard health package, the prison clinic lacks structure and evidence-based research, especially in its “aftercare” programs which are aimed at socially integrating prisoners back into the community.¹³⁷ There is a huge gap in education and awareness when providing harm reduction programs in prisons. In the Sarpoza report, only 31 percent of those surveyed had heard of HIV/AIDS.¹³⁸ NGOs in Kandahar assist with after care programs, but they are not directly connected to the prisons.

A July 2012 report recently stated that one of the male rehabilitation centers and the prison clinic in Kandahar were being shut down from funding constraints; however interviews with MOPH officials suggest otherwise. While the prison clinic has weakened, it could still be functioning on a small scale. Even if it still is operational, reports like these make experts question whether or not short-term projects will impact the effectiveness of drug treatment programs in Kandahar in the future. Can the

135 UNODC, *Drug Use Survey 2010: Sarpoza Prison, Kandahar, Afghanistan* (Kandahar: UNODC, 2010), 2.

136 UNODC, “UNODC brings Medical Care to Prison in Kandahar,” last modified October 10, 2010, <http://www.unodc.org/afghanistan/en/unodcmedicalcare.html>.

137 UNODC, *Drug Use Survey 2010: Sarpoza Prison*, 6.

138 UNODC, *Drug Use Survey 2010: Sarpoza Prison*, 3.

Afghanistan government fund its drug rehabilitation centers independently? If so, were these projected implemented in a way that allows them to be downscaled?

h. Police officers

According to the UNODC, “12 to 41 percent of Afghan police recruits at Regional Training Centers test positive for drugs.”¹³⁹ Initiatives have recently been developed to assist police officers who are addicted to illegal substances. The main objectives of these new political programs are to legitimize law enforcement and improve community awareness regarding drugs and new policies. The case studies revealed that Kabul targeted police and had the most established program in Afghanistan. To assist police officers in Kabul, Afghanistan created a rehabilitation clinic called The Hospital for Interior Ministry Addicts. It is a three to four week advanced program for policemen who have failed their mandatory drug test. It is said to have many qualified staff (ten medical doctors and two psychologist) and a small percentage of policeman that relapse.¹⁴⁰ Some of the explanations to why it has been successful are quality interventions and high motivations. If policemen do test positive for drugs in the future, they will be fired. The hope is that by decreasing addiction rates, the Afghan police force will look more legitimate and be less likely to take bribes since they will no longer need to afford drugs.¹⁴¹

While there is mandatory testing required nationwide, it has not fully gone into effect at the provincial level. Kandahar had one programs available through the Welfare Association for Development of Afghanistan (WADAN), but there was little knowledge on whether it was ongoing. According the WADAN website, of the 1485 Afghan National Police (ANPs) screened, “406 ANPs tested positive for various types of drug abuse.”¹⁴² Education as well as detoxification and intervention services are offered

¹³⁹ UNODC, *Drug Use in Afghanistan: 2009 Survey*, 33.

¹⁴⁰ Rod Nordland, “Sign of Afghan Addiction may also be its Remedy,” *New York Times*, May 16, 2010, 1.

¹⁴¹ UNODC, “Reducing Drug Demand and HIV in Afghanistan, Time Frame: June 2010 – July 2012,” 2.

¹⁴² WADAN, “Drug Control,” ND, <http://www.wadan.org/drug.asp?CatID=9&ContID=103>.

to those who fail the drug tests. Instead of being fired, police officers can return back to the force after they have completed treatment and have shown through drug tests that they are substance free. As far as Badakhshan, there was no evidence of police officer programs existing in the province. This could be because it receives less funding than other at-risk provinces.

6. Component #6: Criminal Justice System

My review of national policies and provincial ability to enforce them suggests that Kabul has low/medium capacity, Kandahar has low/medium capacity, and Badakhshan has low capacity. All three provinces scored poorly in the criminal justice category for three reasons: they had fragile communication networks as result of the drug trade, experienced high rates of corruption, and they lacked institutional capacity in prisons. The reason that Kabul and Kandahar scored equally is because they both have prison programs and social workers in their criminal justice system¹⁴³; yet are both weak and suffer from serious corruption. Badakhshan received the lowest capacity because there is little data on its programs, and it has reported weak enforcement and few police staff, which suggest that it gets fewer resources. To understand Badakhshan's full potential, more research would need to be extrapolated from provincial experts.

Most of its weak infrastructure can be attributed to the drug trade. The National Drug Control Strategies sees the "opium economy as the single greatest challenge to the long-term security of development and effective governance."¹⁴⁴ Afghanistan has collaborated with international partners (mostly the U.S.) on interdiction and eradication as well as on training and mentoring for investigators and justice advisors. According to the U.S. State Department, "From March 2010 to March 2011, the [criminal justice task force] CJTF Primary Court handled 472 cases involving 649 suspects and more than 186.5 metric tons of illicit substances."¹⁴⁵ Even though mentoring has increased

¹⁴³ UNODC, *Afghanistan: Implementing Alternatives to Imprisonment*, 70.

¹⁴⁴ Islamic Republic of Afghanistan MOPH, *Final Policy on Opioid Substitution Therapy* (Kabul: MOPH, 2009), 22.

¹⁴⁵ U.S. State Department, *2012 International Narcotics Control Strategy Report* (Washington, DC: U.S. State Department), 94.

enforcement, citizens and the international community lack confidence in the central government's ability to manage corruption adequately. The Department of State says that enforcement is selective in Afghanistan: "In about one-third of cases from provinces, provincial CNPA[Counter Narcotic Police of Afghanistan] personnel have submitted drugs as evidence to the Justice Center but did not arrest the criminal suspect or suspects."¹⁴⁶ To improve the illicit drug trade, monitoring and prosecution of high-level government officials is needed.

Corruption has additionally been found problematic when providing alternatives to Afghan criminals who have minor drug offenses such as public intoxication or drug possession for personal use. Criminals have the option to either pay a huge fine which puts them in extreme debt or do an alternative program that includes imprisonment; both these initiatives are counterproductive, because high debts, a stressful environment, and easy access to drugs in prison will most likely cause an Afghan to relapse.¹⁴⁷ These alternative programs, which are meant to decrease discrimination and incentivize good behaviors, end up hurting the underprivileged that do not have the ability to bounce back.

There are legal services to assist underprivileged addicts;¹⁴⁸ however the quality is weak and the process is lengthy, because there is a lack of defense attorneys in Afghanistan. The costs of containing prisoners and dealing with the social implications after confinement are additionally taxing for both the international community and Afghan government. Kabul recently did a study on inmates at Pul-e Charki prison and found the following:

A pilot analysis of the cases of 27 first time offenders (all but one of them charged with or convicted of theft or drug related offences) in Pul-e Charki prison revealed that 93 percent were poor or very poor, close to one third of them employed as daily wage earners prior to imprisonment. 81 percent of these prisoners did not have legal counsel. Of the sentences passed, but most still not confirmed by the Supreme Court, 32 per cent

¹⁴⁶ U.S. GAO, "Afghanistan Drug Control," 28.

¹⁴⁷ There has been a Counter Narcotic Law that has been introduced, but it is often done corruptly (with fines that often put prisoners into huge debt) or includes imprisonment after treatment is complete; UNODC, *Afghanistan: Implementing Alternatives to Imprisonment*, xi.

¹⁴⁸ United Kingdom Foreign Commonwealth Office, *Human Rights and Democracy: The 2011 Foreign & Commonwealth Office Report* (London: Foreign & Commonwealth Office, 2011), 159.

would be eligible for the suspension of their sentences if the provisions of the Penal Code were applied and the [Counter Narcotics Law] CNL did not prohibit the application of suspension for drug offences.¹⁴⁹

This study illustrates how aligned poverty, drugs, and criminal acts are in Afghanistan. Networking within the community, to find existing alternatives for convicts is critical for progression in the current justice system. To see improvement in substance abuse rates, a community referral system needs to take place after the addict finishes their alternative program. The Sarpoza Prison in Kandahar has already begun to improve its capacity by working with the Canadian government.¹⁵⁰

7. Component #7: Community Involvement

My evaluation of recovery capital and its ability to instill collective action within the province concludes that Kabul has medium capacity, Kandahar has low/medium, and Badakhshan has low capacity. Kabul is stronger than Kandahar, because it has more resources; but does not deserve medium/high capacity status, because it has failed to put in a proper national referral system. Some of the outreach programs that were mentioned in the case studies were: transitional housing, vocational training, disability, legal advice, mental health counseling, childcare services, nutritional programs and self-help groups. Since childcare services, nutritional programs, legal advice and mental health have been thoroughly discussed in component five, they will not be explained in this section.

The first service is transitional housing; this type of assistance is mostly done by local NGOs. Unfortunately, there is little data on how these programs are structured. Since mental health is not prioritized, research suggests that transitional housing is generalized (less therapy-based) to ensure a large portion of Afghans receive assistance. One example of an effective transitional housing program in Afghanistan is the “House of Hope.”¹⁵¹ It gives a mix of therapeutic and resource-based assistance to female inmates in Kabul so they can “develop life skills and secure employment that will guide

149 UNODC, *Afghanistan: Implementing Alternatives to Imprisonment*, x.

150 “The Canadian Government through their Global Peace and Security Fund (GPSF) is undertaking construction, infrastructure and training at Sarpoza Prison in Kandahar,” UNODC, *Afghanistan: Implementing Alternatives to Imprisonment*, 55.

151 UNODC, “UNODC Chief Visits Transition House.”

them towards being stable and independent.”¹⁵² These types of programs are usually difficult to access, because they are so specialized in providing a wide variety of welfare services. While transitional housing is crucial for reintegration back into the community, it is not prioritized in Kabul, Kandahar, and Badakhshan. All three regions lack resources, capabilities, and community networks to do this on a large scale.

The second service is vocational training; this is being emphasized in all three provinces, because employment is one of the primary reasons for drug dependency. The MOPH has begun to use unemployment opportunities to promote a new vocational program which benefits both the ministry and substance abuse users. Provincial leaders are trying to motivate addicts to volunteer at drug treatment programs in hopes that building manpower will strengthen awareness within the community. In return, addicts can become trained to be a counselor or social worker in the future. This expands recovery capital and gives addicts a reason to maintain their ability to stay of drugs. Former addicts also have potential to make a strong impression on patients, because they can sympathize and relate to similar challenges.

The third service available for addicts is disability. Although Afghanistan has made revisions to the constitution to guarantee rights to disabled individuals, there are no documents that can confirm that these programs are fully implement at the provincial level. The last time the disability list was updated on the MOPH website was 2004. There were 25 organizations for the disabled in Kabul, 7 organizations for the disabled in Kandahar, and 4 organizations for the disabled in Badakhshan.¹⁵³ Poor record keeping suggests that the disabled are not getting referred by drug treatment counselors. If disabled are able to access services, reports cannot confirm how accurate the data is since institutions are constantly changing in Afghanistan.

The fourth and final option, which is located in all three provinces, is religious groups or self-help programs. Many addicts find these groups useful because they can get

¹⁵² UNODC, “UNODC Chief Visits Transition House.”

¹⁵³ UNDP/UNOPS, “List of Institutions and Organizations Working in the Field of Disability in Afghanistan,” last modified August 10, 2004, http://www.undp.org.af/publications/KeyDocuments/ngo_dpo_afghanistan_04.pdf

perspectives from other drug users and can create a support system within their community. The challenge with self-help groups is that they are difficult to access as well as perceived as risky to join because of stigmatization. Drug awareness campaigns that explain addiction as a disease could improve participation of community services.

Todd blames missing information and high relapse rates on a “lack of reliable functioning follow-up system.”¹⁵⁴ There is a disconnect between welfare services and drug rehabilitation centers. Referral systems in Afghanistan are also fragile, because they have constant changeover of staff. While new employees may know how to do quality interventions, they do not have community networks within the drug treatment sector to fully assist their patients. Most community services could be enriched by linking services. In conclusion, all provinces have outreach programs; the problem is that they are not advertised or prioritized. They all have low capacity, because they are not able to get adequate resources from central government.

8. Component #8: Clinical Governance

On clinical governance, I evaluate Kabul as having low/medium capacity while Kandahar and Badakhshan have low capacity. Drug treatment programs in each province lack adequate human resource systems, productivity, and skilled manpower. As mentioned in previous sections, recruiting counselors and police is tough, because the high risks are not worth the low wages.¹⁵⁵ Kabul scored slightly higher for the fact that it is mostly urban and had more access to information, staff, and technology. When it comes to recruitment, Dr. Hamid Folad states that the MOPH is trying to expand its health network and “has took on over 20,000 community health volunteers through the integration of drug addiction treatment services into the BPHS and Essential Package of Hospital Services (EPHS) during the next five years.”¹⁵⁶ He agrees that rural regions are more complex because addiction is not as accepted and locations are not as secure or

¹⁵⁴ Todd, Naqibullah, and Strathdee “Drug Use and Harm Reduction in Afghanistan,” 4.

¹⁵⁵ Treatment Center confirms that recruitment is difficult and reports that low wages are often given to staff months late; U.S. State Department, *2012 International Narcotics Control Strategy Report*, 92.

¹⁵⁶ Dr. Hamid Folad is the Deputy Program Manager for DDR Program at the MOPH

financially stable. On a positive note, he states that patients and healthcare workers' rights and confidentiality are respected at the clinical level.

In the DDR National Policy, the MOPH recognized administrative concerns and highlighted the need for a more sophisticated technical reporting tool.¹⁵⁷ The report further recommends improving clinical governance by developing payroll mechanisms, increasing professional trainings, and establishing a counselor certification process that is approved by both the MOPH and MCN. If more consistent data is collected in health centers and technical systems are enhanced, communication networks can interlink and improve recovery capital. This would improve provincial management systems and increase participation and follow-up from central governance. It would also improve collaboration between the ministries and the international community.

Even though donor agencies list human resource protocols in their report outcomes, they lack administrative guidance in how to move forward. Since they cannot monitor Kandahar and Badakhshan consistently, they cannot ensure that new clinical governance policies are being enforced at the treatment centers. Little information is known in how staff is recruited, how treatment centers do performance reviews, corruption within the drug treatment clinics, and how management monitor staff burnout. While clinical governance is going to be a challenging undertaking, it will be crucial in creating a creditable and sustainable national drug addiction program.

9. Component #9: Coordination of Services

My assessment of community involvement and recovery capital in Afghanistan concludes that Kabul and Kandahar have low/medium capacity while Badakhshan has low capacity. Even though Kabul and Kandahar received the same score, it should be noted that Kabul is much stronger in coordinating services at the provincial level. It did not receive a medium score because it has failed in implementing a national drug treatment referral program. Drug treatment programs have remained fragile in all provinces, because Afghanistan has not prioritized addiction rates and provincial

¹⁵⁷ Islamic Republic of Afghanistan Ministry of Counter Narcotics, *National Drug Demand Reduction Policy 2012–2016*, 35.

partnerships. Coordination between social welfare, the criminal justice system, and health facilities is almost non-existent in most provinces.

Institutional concerns and accessibility of services would improve if Kabul, Kandahar, and Badakhshan had a national/provincial information system from which to build multidisciplinary teams. Creating a more complex technical network would ensure more accurate data which would decrease doubts regarding key players' motives. Both Badakhshan and Kandahar are known to have inconsistent communication with the central government. Kandahar scored slightly higher on the nine components because tribal groups have been effective in recruiting volunteers (component 2) and delivering services to multiple population groups (component 5) despite having high levels of conflict among them.

Three obstacles prohibit provincial health networks from communicating regularly: services in certain locations are difficult to reach, conflict deters progress, and donor funds are misinterpreted. Environmental constraints prohibit an effective partnership, because it is physically difficult to contact health facilities in rural regions. While this is not a problem for Kabul, it is for Badakhshan and Kandahar—limited technological capacity and public infrastructure (e.g., paved roads and communication networks) makes it problematic for provincial capitals to communicate regularly.

Badakhshan struggles the most in communication with local and central leaders, because it is mountainous and snowy. For example, one addict stressed how difficult it was to get to an opium treatment center in Badakhshan; it is “more [than] four hours ride on the bumpy road.”¹⁵⁸ Another report in Tushkan District states that “lack of new roads and bad condition of existing roads has caused mother and infant mortality and it takes the residents 24 hours to take their goods and commodities to market by donkeys.”¹⁵⁹ Distance discourages health awareness campaigns and keeps residents from becoming

158 UNODC, “Life in the Mountains of Badakhshan: The Burden of Past Opium Dependence,” last modified September 5, 2010, <http://www.unodc.org/afghanistan/en/frontpage/2010/September/life-in-the-mountains-of-badakhshan.html>

159. Tushkan District Development Assembly with the facilitation of NABDP/MRRD and support of the District and Provincial Governors, *Summary of District Development Plan: Tushkan District, Badakhshan Province* (Badakhshan: MOPH, 2008), 3.

more active in advocating for social concerns. Environmental concerns were addressed by a survey in Northern Afghanistan that sought to better understand how primary care works in post-conflict communities. After speaking with patients and collecting data from different districts, the survey recommended that Northern Afghanistan incorporate more mobile clinics to increase local participation.¹⁶⁰ Yet drug rehabilitation programs cannot be included in mobile clinics. Between low-quality personnel and minimal resources, mobile clinics would not be able to provide adequate mental health care.

The second reason for weak alliances is conflict. Of the three case studies, violence has been the most devastating in Kandahar. Warlords and commanders have been intervening in drug treatment policies. The central government and international community have failed in their promises to reduce the insurgent threat. In fact, insurgent attacks have worsened in some regions in Southern Afghanistan as a result of donor assistance. In addition to violence, poverty and corruption from the drug trade have implanted doubts regarding outsider's intentions. There are concerns from residents that tribal leaders, provincial government officials, and donors may be strategizing for their own financial gain, instead of doing what is best for the region. Provincial leaders in Kandahar are frustrated because they feel their suggestions regarding social grievances are not being taken into account. Suspensions in partnerships keep both sides from reaching a consensus; this is noticeable in culturally sensitive issues like harm reduction services. Even though recovery capital is fairly strong in Kandahar, there is concern that social services will weaken if mistrust continues, particularly if donors decide to leave.

The third reason for a decline in partnerships has to do with funding constraints, inaccurate data, and overrepresentation of donor resources at the local and national level. As mentioned in the case studies, it is hard to determine what treatment centers are still open for business. Addiction statistics are constantly changing and current reports seem to show a downward trend in resources, even though significantly more reports are being written on the impacts of drug addiction in Afghanistan. Misconstrued data has additionally made it impossible to evaluate drug treatment capabilities. Statistics are

¹⁶⁰ Morikawa et al., "Primary Care in Post-Conflict Rural Northern Afghanistan," *Public Health* 125, no. 1 (2011): 55.

missing from private organizations, non-profits, and smaller-scale clinics. One explanation is that funds were dispensed inefficiently so managers decided to transfer responsibilities or consolidate treatment. If this is the case, then changes in the data may not necessarily be a bad thing—a decrease in centers is only negative if there is also a decrease in quality.

The other explanation is that these treatment centers never existed at all and that donors or the Afghan government used the funds to benefit themselves. For example, short term projects may have been obligated from donors without any follow-through. Either way, it is almost impossible to evaluate data through services rendered because Afghanistan is constantly changing in its socio-economic and political status. This situation could be improved by more intense collaboration during the assessment. Short-term programs have been useful in assisting the underprivileged quickly and bringing awareness, but have unfortunately decreased the participatory response needed to improve recovery capital for drug addicts. To improve partnerships in all three provinces, maintenance and follow-through should be prioritized.

IV. CASE STUDY CONTEXTUALIZATION

This chapter assesses geographical, political, economic, and cultural barriers to determine how individual-level variables impact recovery capital in Kabul, Kandahar and Badakhshan. Each case study begins by providing a comprehensive background that describes the variation between drug treatment centers in each region. It contains insights as to why cultural and geographical nuances either promote or suppress a positive response. The literature review questions posed in Table 2, Table 3, and Table 4 are then extrapolated to create an empirical framework to assess provincial capability and recovery capital. Lastly, the case studies highlight why stronger economic/political policies and psychological programs produce higher quality drug treatment programs. The expectation is that more developed socio economic regions, like Kabul, will have stronger community assistance networks which will decrease an addict's desire to use poppy as a way of survival. Regions like Kandahar and Badakhshan will have lower quality of drug treatment programs; because they receive less donors assistance, socio-economic support, and are less aware of national policies that could advocate for at-risk groups.

A. CASE STUDY- KABUL PROVINCE

Table 7. Kabul: Assessment of Structural Dimensions¹⁶¹

Psychological Barriers in Kabul					
Do Health Networks Collaborate to Improve Recovery Capital?	Are there systems in place to assist ex-combatants with PTSD?	Are programs confidential?	Are their enough trained counselors and pharmacists?	Are clinics giving medication to patients to fight urges?	Are patients being taught behavioral techniques to manage and cope with urges?
Yes, but most connections are weak.	Yes, only mental health hospital in Afghanistan	Yes, but stigmatization is still a problem	No, but Kabul has the most in Afghanistan	Yes, but the case study is small and not supported by ministries	Yes, but limited staff.
Economic Barriers in Kabul					
What is the poverty rate? Are there adequate welfare services for poor?	Are there enough employment opportunities for locals?	Is technology available? Does it link other community networks?		Are market’s diverse? Is opium the main source of income?	Are financial institutions structured in a way that incentivizes the rich to invest in welfare programs?
Poverty somewhat high. 23.1% compared to 35.8% national average. Some services, but limited.	Somewhat. 10.7% compared to 7.9%. Higher because of large migration population.	High technological capabilities. 85.7% can access electricity compared to 41.1% national average. It has capacity to link, but other provinces are too poor to do so.		Yes. 50.1% in services, 16.5%, in agriculture, 16.9% in manufacturing, and 16.4% in public administration. Low Opium production.	No. This is evident from corruption levels.
Security/Governance Barriers in Kabul					
Is the region secure?	Is corruption managed?	Are there enough qualified police working in the province? Are there special programs for addicts who are policemen?		Is there drug treatment services provided in prisons?	Is the justice system enforcing drug policies?
Safer than most regions.	No. Only 40% accept bribes; however it is considered to have the worst corruption in Afghanistan.	There are not enough police officers, but there is addiction programs connected to the justice system.		Some harm reduction, yet limited.	Yes, but not consistently. This is evident from corruption levels.

¹⁶¹ Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 27–28; UNODC Statistics and Surveys Section, *Corruption in Afghanistan: Bribery as Reported by the Victims* (Kabul: UNODC, 2010), 29–30.

1. Provincial Strengths

This Kabul case study will provide political and economic background to questions asked in the literature review (Table 7), pinpoint barriers to effectiveness, and give explanations to why Kabul has the strongest drug treatment programs in Afghanistan. Most of Kabul's increased institutional and technical capacity can be attributed to four reasons: its status as the nation's capital, its more established political and economic markets, its linkage to local and international contributors, and its evidence based research.

The reason why its location is more advanced is because it is the primary place in the country where political change originates. It is where the largest portion of senior government and international officials reside, where policies are established, and where new economic strategies are initiated. Its more advanced urban environment has the potential to give residents a sense of hope for a better lifestyle, and in effect, deters residents from using illegal substances as a coping mechanism. In addition, the competitive atmosphere and comfortable living conditions (e.g., clean water and electricity)¹⁶² reduce the likelihood that educated residents in psychology, policy, or the health field will move to another region in Afghanistan for employment. Having long-term staff in Kabul has been beneficial in developing a more enriched referral system (when compared to other provinces), providing cultural perspective, and having more collective action when creating individualized plans for special populations.

The second reason for Kabul's enhanced capabilities has to do with its connections to political and economic networks. Its unique position has given Kabul a large advantage when implementing policies and developing markets. Program directors have been able to receive a quick response from central government, advocate for resources, and play a more participatory role in the reconstruction process. The economy

¹⁶² Living conditions has improved significantly; Kabul residents who live in urban areas have access to electricity 24 hours a day as a result of recent international efforts to partner with Uzbekistan; IEEE Global History Network, "Electricity Supply in Afghanistan," last modified 2012, http://www.ieeeghn.org/wiki/index.php/Electricity_Supply_in_Afghanistan

in Kabul is quite diverse and strong (when compared to other provinces),¹⁶³ and has been influential in deterring residents from being employed in the illicit drug industry. While slight increases in poppy production are expected, the UNODC states that security is strong in Kabul and the province's role in cultivation is insignificant, since it has been restricted to Surobi district.¹⁶⁴

The third explanation for its progression is that Kabul has aligned with stronger networks to enrich its drug treatment programs. The MOPH and the MCN have studied obstacles that prohibit addicts from seeking help in Kabul and have been instrumental in the transformation of a more community based approach. Less time and money is spent when communication gaps are addressed. Since the majority of ministry officials are based in the capital, they can partner psychologists and academics in Kabul with international donors. These international connections give Kabul experts an advantage when doing business, because they already have a relationship and can have conversations about expectations prior to submitting research proposals; for example, the MOPH partnered with donors to improve the refugee population in Kabul. Resources may have not been so rich if addiction around the "Pul-sokhta" Bridge and the Old Russian Cultural Center were not so heavily advertised to the international community.

Kabul's fourth reason for being seen as the most advanced in Afghanistan can be attributed to its research capabilities which have enhanced drug treatment programs ability to provide more quality interventions. Some of the fields that do drug treatment studies are: psychology, drug trafficking, human rights, and HIV/AIDS.¹⁶⁵ Evidence-based interventions increase success rates, provide psychological insights into counteracting substance abuse in Kabul, and evaluate target populations. Results are oftentimes briefed in international forums to ensure there is consensus on best ways to move forward. Donors prefer conducting evidence-based research in Kabul, because

¹⁶³ Trade and services provide over half of all household incomes while manufacturing, agriculture, and public administration/government account for a substantial percentage of other household salaries; Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 28.

¹⁶⁴ UNODC, *Afghanistan Opium Survey 2011: Winter Rapid Assessment for the Central, Eastern, Southern and Western Regions* (Kabul: UNODC and MCN, 2011), 19.

¹⁶⁵ U.S. State Department, "Demand Reduction Program: Afghanistan."

there is advanced technology, experts are likely to speak English, it is a neutral/somewhat safe location, and researchers can request assistance from the ministries if problems arise. The perspective that Kabul is the “research hub” was reinforced when reviewing articles on substance abuse in Afghanistan; studies that promoted preventative health and drug treatment referenced Kabul the most out of any other province. In addition to publications, Kabul was found to have an abundance of harm reduction, drug treatment, and welfare services when compared to other provinces in Afghanistan. This is primarily because of donor influence within Kabul and its high percentage of educated experts who can advocate for the poor.¹⁶⁶

2. Provincial Weaknesses

While Kabul’s drug treatment capabilities are more advanced than other Afghan provinces, it should be noted that its research capacity is still limited when paralleled to other developing countries. There are two explanations for Kabul’s inadequacies: its corruption restricts the poor from advocating and accessing services and its ongoing violence prohibits national economic advancement. The first and most concerning issue for Kabul residents is corruption. Policy constraints and dishonesty within government have created friction between citizens and central authority. One national study found that over 60% of individual’s perceived Kabul province as having the worst corruption in Afghanistan.¹⁶⁷ Regulations in Kabul are weak, because the insurgent movement uses corruption in Afghanistan as a funding and propaganda source.

Landler says that corruption is one of the best ways to recruit new Taliban members, because it reinforces the need for a more legitimate government.¹⁶⁸ Many residents have lost faith in Karzai’s leadership, because they feel his institutions are structured to benefit the rich. This has been seen when developing drug treatment programs throughout Afghanistan; there are very few avenues for the underprivileged.

¹⁶⁶ The Literacy rate age 16 and older is 46.8 percent in Kabul, compared to the 25.0 percent national average; Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 28.

¹⁶⁷ UNODC Statistics and Surveys Section, *Corruption in Afghanistan: Bribery*, 29–30.

¹⁶⁸ Mark Landler, “Envoy Says Corruption Helps Taliban Win Recruits,” *The New York Times*, July 28, 2010, 1.

While there are a few services, they are difficult to access, because central government has failed to create a nation drug referral system. Most addicts express a need for psychological and economic support, but feel it is impossible to access. The central government has introduced strong ideas, but they lack follow-through, are not always thought out, and are inconsistent.

While policies were created with good intentions, programs have backfired. A great example of this was shown when evaluating the criminal justice section; alternative prison programs were found to be counterproductive and put prisoners in large debts. While funds have been expended to improve addiction rates in Kabul, the central government still lacks administrative capacity to ensure that resources are given transparently to drug treatment programs.

While the U.S. has collaborated closely with Karzai to improve accountability and transparency, there are concerns that his “reluctance to prosecute officials for corruption, particularly those related to him or aligned with him politically,” could prohibit implementation of anti-corruption policies.¹⁶⁹ For example, the collapse of the Kabul Bank is an excellent illustration of how high profile or “well connected Afghans have avoided regulations and other restrictions in order to garner personal profit.”¹⁷⁰ Karzai’s actions to selectively prosecute officials are weakening Afghanistan’s justice system. While international organizations are aware of corruption concerns, it is difficult for them to assist, because Afghan criminals are well protected by high-ranked officials. Underprivileged residents, who are aware of the “Malign Actor Networks,” refuse to testify, because their confession could cause them to be targeted.¹⁷¹ The international community cannot improve the justice system without more participatory efforts from central government.

¹⁶⁹ Kenneth Katzman, *Afghanistan: Politics, Elections, and Government Performance* (Washington, D.C.: Congressional Research Service, 2012), 41.

¹⁷⁰ Kenneth Katzman, *Afghanistan: Politics, Elections, and Government Performance*, 46.

¹⁷¹ Mathew Rosenberg, “‘Malign’ Afghans Targeted,” *The Wall Street Journal*, December 29, 2012, 1.

The second reason that Kabul struggles to improve capacity in drug treatment programs is that violence deters provincial progress. Part of this concern is stemmed from corruption because fraudulent acts delegitimize Kabul's police force and make it more difficult to recruit officers. Even though Kabul is seen as the safest region for foreigners in Afghanistan, it still experiences conflict on a continuous basis. For example, in 2010, Kabul officials reported "110 antigovernment attacks from January to September."¹⁷² In addition to terrorism, over-populated areas have become difficult to enforce; and as a result, there has been an increase in individual assaults, kidnappings, and robberies in Kabul.¹⁷³ Reoccurring violence has instilled scarce confidence in law enforcement capabilities and uncertainty in Afghanistan's economic future. The international community would prefer to invest in countries which are less risky, more secure, transparent, and profitable. The state of violence in Kabul is especially concerning as international troops begin to leave Afghanistan. Residents worry that businesses will decline as donors develop elsewhere. One businessman in Kabul said that "his business is already drying up and that in approximately two years he will close up shop and leave Afghanistan."¹⁷⁴

¹⁷² This article was released after a NATO representative stated that Kabul is probably safer than New York or London; Ben Arnoldy, "Kabul 'safer' for kids than London or New York, says NATO." *The Christian Science Monitor*, November 22, 2010, 2.

¹⁷³ Chris Sands, "Population Growth Overwhelms Kabul," *The National*, August 30, 2008: 1.

¹⁷⁴ Steven Zyck, *Opium Poppies & the Afghan Economy* (Civil-Military Fusion Centre: Afghanistan in Transition, 2012), 1.

B. CASE STUDY- KANDAHAR

Table 8. Kandahar: Assessment of Structural Dimensions¹⁷⁵

Psychological Barriers in Kandahar					
Do Health Networks Collaborate to Improve Recovery Capital?	Are there systems in place to assist ex-combatants with PTSD?	Are programs confidential?	Are there enough trained counselors and pharmacists?	Are clinics giving medication to patients to fight urges?	Are patients being taught behavioral techniques to manage and cope with urges?
Yes, but most connections are weak.	No. Can access mental health through hospitals, but must be referred to Kabul for severe psychiatric services.	Yes, but there is high stigmatization	No	No	Yes, but limited staff to assist entire province.
Economic Barriers in Kandahar					
What is the poverty rate? Are there adequate welfare services for poor?	Are there enough employment opportunities for locals?	Is technology available? Does it link other community networks?		Are market's diverse? Is opium the main source of income?	Are financial institutions structured in a way that incentivizes the rich to invest in welfare programs?
Poverty somewhat high. 22.8% compared to 35.8% national average. Some services but limited.	Yes. 4.4% unemployed compared to 7.9% average.	Low technological capabilities with make it impossible to link to other networks. 25.4% can access services compared to 41.1% national average.		Somewhat diversified. 45.3% in agriculture and 42.5% in services. Has high cultivation; however there was a moderate decline last year.	No. This is evident from corruption levels.
Security/Governance Barriers in Kandahar					
Is the region secure?	Is corruption managed?	Are there enough qualified police working in the province? Are there special programs for addicts who are policemen?		Is there drug treatment services provided in prisons?	Is the justice system enforcing drug policies?
No	No. 61.5% accept bribes in Southern region of Afghanistan.	No. There was one police program, but it was extremely limited and research didn't confirm whether it was ongoing.		The prison has a drug treatment clinic and harm reduction services; however there is concerns regarding closure.	No. This is evident from corruption levels.

¹⁷⁵ Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 29–30; UNODC Statistics and Surveys Section, *Corruption in Afghanistan: Bribery*, 19.

1. Provincial Strengths

This case study evaluates Kandahar's drug treatment capacity through the literature review questions above, explains why the region is stronger than Badakhshan province in providing services to addicts, and identifies how the international community and the central government can contribute in developing addiction programs in an insecure environment. It is a unique province to study, because the region is known to be involved in the drug trade; nevertheless there seems to be heavy stigmatization of drug users. Its ability to overcome its instability and to be seen as one of the stronger drug treatment provinces is an achievement in its own. Its strengths can be attributed to three reasons: high donor funds, increased efforts to combat counter narcotics, and participation from tribal networks.

The first reason that Kandahar is stronger than Badakhshan is that it receives heavy donor assistance from the international community. Kandahar has used these funds to create welfare service programs for substance abuse users that have been proven constructive in increasing provincial living conditions. In fact, when evaluating the three case studies, research found that Kandahar had the lowest unemployment and poverty rate.¹⁷⁶ While this statistic is promising, household stability should be further questioned to understand the significance of this measurement. While it has lower poverty rates than Kabul, there are more households in Kandahar which reported economic hardship.¹⁷⁷ This could mean two things: that Kabul's statistics are skewed because of their high refugee population or that the majority of households are receiving inconsistent income through the illicit drug industry and while they are less poor overall, Kandahar's residents receive less assistance when they need it. While the measurements given cannot provide

¹⁷⁶ Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 31.

¹⁷⁷ The 2005 NRVA reports that 38% never, 22% rarely (1–3 times a year), 33% sometimes (3–6 times a year) 4% often (few times a month) and 3 percent mostly (happens a lot) have trouble satisfying food needs; The World Programme, "Provincial Profile," last modified 2012, <http://www.foodsecurityatlas.org/afg/country/provincial-Profile>; (22.8% poverty rate compared to 35.8 national average) Islamic Republic of Afghanistan Ministry of Economy and World Bank. *Afghanistan Provincial Briefs*, 29

accurate insight, Kandahar's should be acknowledged for its improvement in getting services to the underprivileged.

The second explanation for improvements in Kandahar's drug treatment programs is that it has created economic incentives to avoid the drug industry. While addiction rates are still extremely high, new economic opportunities have made residents less reliant on corrupt institutions which should decreased their risk of experimenting with drugs in the future. Recent data suggest that there has been a moderate decline in opium cultivation in Kandahar due to less violence, fear of eradication, campaigning, and development programs.¹⁷⁸ International donors have changed their tactics and put substantial funds towards counter-narcotics while simultaneously diversifying markets. Current statistics show that Kandahar has begun to economically diversify; however, employment is still predominantly in two sectors.¹⁷⁹ The hope is that continued resources and employment opportunities in Kandahar will improve security, and in effect, reduce anti-government ties in the future. Market growth in Kandahar will likely depend on its ability to decrease the insurgency, which is somewhat concerning considering that Southern Afghanistan is known for its Taliban involvement and high casualty rates.

Strong tribal groups are the third and final explanation for why Kandahar is stronger than Badakhshan. Influential leaders have improved communication systems and connected services within the drug treatment community. While these complex tribal networks do not necessarily approve of central government, they do have the same goal in combatting drug addiction. The majority of citizens in Kandahar speaks Pashto and belongs to the following five tribal groups: Popalzai, Barakzai, Alkozai, Noorzai, and Lezai. Dupree states that there are six socio-cultural themes that can be seen in tribes in Afghanistan: multilingualism, illiteracy, agriculture and pastoral characteristics, lack of

¹⁷⁸ UNODC, *Afghanistan Opium Survey 2011: Winter Rapid Assessment*, 1.

¹⁷⁹ The 2007–2008 NRVA report has the top five sources of income being agriculture (45.3%), Manufacturing/Construction/Mining/Quarrying (10.6%), Services (42.5%), and Public Administration/Government (1.6%); Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 30.

social mobility, limited social exposure, and dominance of kinship.¹⁸⁰ Participation from tribal leaders has been beneficial in helping donors fully comprehend the complexity of the province. Their inputs have ensured that new programs maintain a traditional structure while concurrently adhering to the social themes of residents. Since tribal leaders have such deeply aligned ties, they have been instrumental in: drug awareness and prevention campaigns, managing culturally sensitive issues, recruiting community volunteers, and motivating individuals to seek treatment. Continued cooperation from powerful community leaders could significantly improve the capacity of drug treatment programs in the future.

2. Provincial Weaknesses

This section assesses Kandahar's drug treatment programs to understand why its infrastructure is still weak despite receiving such strong donor assistance. It describes political and economic barriers, explains community perceptions, and gives guidance on lessons learned. There are five explanations to why Kandahar is not as strong as Kabul: its insecurity is prioritized over development, its weak law enforcement instills corruption, its low human capital reduces capabilities, its complex government system creates social stigmatization, and its poor evaluation process encourages more short-term thinking.

The first reason why Kandahar has weak drug treatment capacity is that it is a geographically unstable region. Southern Afghanistan is closely aligned with the Taliban, is highly involved in the illicit drug industry, and is seen as a safe haven for Anti-Government Forces (AGF).¹⁸¹ Security has had to be prioritized over all other efforts. For example, one Kandahar security report stated that "in the first four months of 2010,

¹⁸⁰ Joan Sullivan-Owomoyela and Laura Brannelly, *Promoting Participation: Community Contributions to Education in Conflict Situations* (Reading, UK: UNESCO, 2009), 54.

¹⁸¹ Sophia Woodcock, *Socio-Economic and Psychological Assessment of fluctuation and Variations of Opium Poppy Cultivation in Key Provinces in Afghanistan: Balkh, Kandahar, Nangarhar, and Central Provinces* (Kabul: UNODC, 2006), 51.

there were at least 64 assassinations.”¹⁸² The Taliban supports the drug industry, because it is a major source of income for the insurgency movement and reinforces the argument that a more legitimate power is needed in central governance. Woodcock describes the mentality towards Taliban initiatives as, “forcefully advocating the concept that Pashtuns should be reinstated as the main rulers of Afghanistan. They are motivated by short term considerations, believing that force can be applied to any future problems that they have not conceptualized.”¹⁸³ Drug trafficking, opium cultivation, and heroin processing laboratories have halted reconstruction in Kandahar, because they have exasperated violence, instilled corruption, and delegitimized efforts by the international community.

The second challenge is that Kandahar lacks police officers to deter conflict and a strong justice system to tackle legal disputes.¹⁸⁴ The Afghan National Police (ANP) force has been ineffective and incapable of managing the insurgency. Experts like Forsberg blame this on corruption. He suggests that local powerbrokers deliberately weakened or manipulated the police force for political and financial gain.¹⁸⁵ While corruption is a problem in all three case studies, it has been particularly problematic in Kandahar because it has strengthened the resistance. Problems will continue to persist as long as financial infrastructure is constructed in a way which favors the drug industry. Recent efforts to legitimize law enforcement have been somewhat effective; however perceptions will remain if police recruitment rates are not improved and policies not enforced.

The third reason that Kandahar struggles to provide its citizen’s resources is poverty. Poverty increases addictions rates and reduces human capital in the region. While opium production is contrary to Islam beliefs, many residents perceive the drug industry as a survival tactic. It is difficult for farmers to switch to a more legitimate crop

182 Anand Gopal, *The Battle for Afghanistan: Militancy and Conflict in Kandahar* (Washington, DC: New America Foundation, 2010), 38.

183 Woodcock, *Socio-Economic and Psychological Assessment*, 8

184 Paraag Shukla, *Battlefield Update: Task Force dreadnaught in Maiwand District, Kandahar* (Washington, DC: Institute for the Study of War, 2012), 3.

185 Forsberg, “Politics and Power in Kandahar,” 47.

when they see poppy as a “more attractive option for the household,” explains McCoy.¹⁸⁶ While participating in the drug trade can be profitable, it can also be risky. Drug traffickers and opium farmers in Kandahar are more vulnerable to addiction, because they are more likely to experience poverty, unemployment, violence, or loss of family members. Recent data suggests that there are approximately 100,000 addicts in Kandahar province alone.¹⁸⁷

Even though the international community has taken steps to diversify economic markets and decrease poverty, Kandahar has a long way to go before it can provide drug treatment and social services to all of its citizens. More long-term planning needs to be done to ensure drug treatment infrastructure is more sustainable. For example, Kandahar still has extremely low literacy rates,¹⁸⁸ which has reduced the amount of educated counselors and social workers and weakened specialized care. Those who are educated often leave because of low wages and unsafe conditions. Its low rates are partly due to tribal influence, since illiteracy is one of the six socio-cultural themes present in most groups. More communications with tribal leaders on this specific issue could be beneficial in the future.

Kandahar’s fourth weakness is that donors and central government have a fragile relationship with key provincial leaders. While tribal groups have been beneficial in expanding community services, they are only cooperative on initiatives which they find are important. A great example of this can be seen with harm reduction services; they are strong in their beliefs that programs should remain abstinence-based. Tribal networks have also been selective in clans which they assist. Partnerships between clans are resilient, because “tribal politics [are] deeply entwined with governance.”¹⁸⁹ Forsberg

186 Alfred McCoy, *The Politics of Heroin: CIA Complicity in the Global Drug Trade* (Chicago: Lawrence Hill Books, 2003), 505.

187 Relief Web, “Afghanistan: Despite Counter-Narcotics Efforts, Number of Drug Addicts still High in Kandahar,” last modified June 27, 2012, <http://reliefweb.int/report/afghanistan/despite-counter-narcotics-efforts-number-drug-addicts-still-high-kandahar>.

188 Literacy rate is extremely poor at 7.3%; Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 30.

189 Gopal, *The Battle for Afghanistan: Militancy and Conflict in Kandahar*, 5.

compares them to mafia networks, where leaders maintain power and influence by organizing their cartels along tribal lines.¹⁹⁰ While collaboration with tribal networks is vital to drug treatment success, program leaders should be mindful when applying new processes.

The fifth challenge is that instability in Kandahar and negative attitudes toward central government has made it difficult for outsiders to play an active role in constructing drug treatment programs. Communication between donors, the ministries, and provincial leaders could be improved by developing a national referral system. Kandahar needs to come up with a plan to ensure that drug treatment continues as donors become less interested in the region. There are serious concerns, both locally and worldwide, that insurgent attacks will increase once international troops depart Afghanistan. This sense of hopelessness could potentially drive more residents to drug addiction and made it difficult to change residents' mentality towards the international community.

¹⁹⁰ Forsberg, "Politics and Power in Kandahar," 11.

C. CASE STUDY- BADAKHSHAN

Table 9. Badakhshan: Assessment of Structural Dimensions¹⁹¹

Psychological Barriers in Badakhshan					
Do Health Networks Collaborate to Improve Recovery Capital?	Are there systems in place to assist ex-combatants with PTSD?	Are programs confidential?	Are their enough trained counselors and pharmacists?	Are clinics giving medication to patients to fight urges?	Are patients being taught behavioral techniques to manage and cope with urges?
Collaboration extremely weak	No	Yes, but still stigmatization	No	No	Yes, but limited in skilled staff
Economic Barriers in Badakhshan					
What is the poverty rate? Are there adequate welfare services for poor?	Are there enough employment opportunities for locals?	Is technology available? Does it link other community networks?		Are market's diverse? Is opium the main source of income?	Are financial institutions structured in a way that incentivizes the rich to invest in welfare programs?
Extremely high poverty rate. 61% compared to 36% national average. Very few welfare services.	No. 12% unemployed compared to 8% average.	Low technological capabilities. 37% can access services compared to 41% national average.		Little diversity. 70% involved in agriculture. Previously opium free, but expecting increases.	No. This is evident from corruption levels.
Security/Governance Barriers in Badakhshan					
Is the region secure?	Is corruption managed?	Are there enough qualified police working in the province? Are there special programs for addicts who are policemen?		Is there drug treatment services provided in prisons?	Is the justice system enforcing drug policies?
Relatively safe compared to other provinces	No. 60.9% individuals accept bribes in Northern region of Afghanistan.	No. Lack of qualified experts.		Harm reduction services; however extremely limited.	No. This is evident from corruption levels. Lack staff and resources to enforce policies.

¹⁹¹ Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 1–2; UNODC Statistics and Surveys Section, *Corruption in Afghanistan*, 19.

1. Provincial Strengths

While Badakhshan is noticeably weaker than the other two provinces, it does have significantly more resources for addicts than other Afghan regions. These three provinces were specifically chosen for their strengths, because there had to be enough research available and infrastructure in place to fully grasp each province's drug treatment capability. Badakhshan should receive positive acknowledgment for the fact that it has been proactive and had the foresight to see that its residents were more susceptible to drug use. The province should be recognized for two strengths, in particular: its ability to maintain a relatively safe region and to target special populations despite such small donor funds. While Badakhshan has experienced much corruption and illicit drug trafficking, it has been able to maintain low opium cultivation and has had few insurgent attacks. In addition, it should be commended for its commitment to prioritizing women and children in its drug treatment programs. There are few provinces that have targeted this special population, which shows that the region is trying to be more progressive while still maintaining the family-based approach that is important to its residents. It also has potential to continue its economic diversification through tourism, agriculture, and its large coal and mineral reserves. If Badakhshan is able to maintain this stability, access more donor funds, and develop a more community-based approach in the health and social welfare sector, it may see economic progress and less addiction rates in the future.

2. Provincial Weaknesses

This section examines drug treatment centers, compares the results of the literature review questions above, and explains why Badakhshan lacks capacity in its programs despite the fact that it is located in a relatively stable region. There are four reasons to why Badakhshan is perceived as the weakest: decreased human capital prohibits economic growth, its geographic position is complex, corruption has illegitimized its justice system, and weak infrastructure decreases networking capabilities. While these problems are all concerning, this thesis recommends that Badakhshan put poverty at the forefront because it has the most potential for creating constructive change. The other obstacles are vital in building provincial capacity;

however economically assisting impoverished citizens is the one solution that is linked to all of the obstacles mentioned above.

The first explanation for Badakhshan's lower level of capacity is its decrease in human capital: extreme poverty prevents residents from taking a more active leadership role in the community. Even though the province has economic potential, in terms of agriculture and the trade industry, most residents find it difficult to survive off of their household income.¹⁹² In fact, two thirds of citizens have taken on debt because they did not have sufficient salary to pay for food.¹⁹³ In addition, impoverished residents have reported difficulty in accessing clean water, healthcare, and electricity. Such severe poverty has created uncertainty throughout the region and made it difficult for provincial leaders to think in the long term. Individuals oftentimes choose working over education, because it ensures survival. Those who are educated normally move to the capital where they can receive a larger income and live a more comfortable lifestyle. Lower education rates mean¹⁹⁴ that there are fewer professionals in the province that are capable of conducting evidence based drug treatment, enforcing counternarcotic policies, and providing basic medical care.

The lack of human capital has also deterred more diverse economic infrastructure. While international funds have been given to diversify the region and strengthen markets, they have not been successful in doing so. Badakhshan has had to rely on foreign agencies, which are inconsistent in providing healthcare and welfare services. International organizations have expanded schools, electricity, and roads; however, more is required to fill such an extreme poverty gap and donors are finding that their efforts are unsustainable without central governments cooperation. As foreigners decrease their presences, government will need to take a more active role in providing assistance. If

¹⁹² "Around half the households in the province (48%) report having problems satisfying their food needs at least 3 – 6 times a year, and a further quarter of households (27%) face this problem up to three times a year;" The World Programme, "Provincial Profile."

¹⁹³ In 2005, 24% of the population of Badakhshan Province received allocations of food aid. In addition, of the 36% of households who reported taking out loans around two thirds (67%) said that the main use of their largest loan was to buy food. A further 11% used the money to cover expenses for health emergencies;" The World Programme, "Provincial Profile."

¹⁹⁴ The literacy rate for individuals 16 years and above is currently at 26.5 percent; Islamic Republic of Afghanistan Ministry of Economy and World Bank, *Afghanistan Provincial Briefs*, 2.

they do not, residents may take more risky employment to ensure survival. Extreme poverty has incentivized many farmers to revert back to the illicit drug industry. Northern Afghanistan previously had an “opium free status,” but recent data suggests that there will be an increase in the next coming year,¹⁹⁵ which could instill conflict in the future. Residents are frustrated with donors and central government because they have failed to meet the promise of “greater levels of development funding” if they discontinued opium cultivation.¹⁹⁶

Badakhshan’s third reason for inefficiencies can be attributed to its geographical location. Northern Afghanistan has struggled to develop infrastructure, because “the ban on opium cultivation has coincided with prolonged and repeat droughts.”¹⁹⁷ With its high mountain ranges (Hindu Kush and Pamir) and its proximity to the border, the northeast region is seen as one of the main transit routes for opium and heroin being trafficked to Central Asia, Europe, and Russia. Badakhshan and Nangarhar are used as a pit stop for traffickers, because they prefer to refine morphine base to heroin before crossing the border.¹⁹⁸ Once in Tajikistan, smugglers trade with the Russian Mafia for arms—because they can thereby double their profits when they return back to Afghanistan.¹⁹⁹ Being near the border additionally increases resident’s chances of becoming addicted, because they are more likely to be around or know someone who is involved in the drug trade. Residents are more at risk to be exposed to a variety of potent and addictive drugs from neighboring countries. This is a threat because these drugs have the potential to promote an infectious outbreak if not managed correctly. This being said, their unique position (drug traffickers, heroin laboratories, and high addiction rates) has made drug treatment

195 UNODC, “UNODC Chief Visits Northern Afghan Province of Badakhshan,” last modified May 13, 2012, <http://www.unodc.org/unodc/en/frontpage/2012/May/unodc-chief-visits-northern-afghan-province-of-badakhshan.htm>.

196 Adam Pain, *Opium Poppy Strikes Back: The 2011 Return of Opium in Balkh and Badakhshan Provinces* (Kabul: Afghan Research and Evaluation Unit, 2011), 1.

197 Paula Kantor and Adam Pain, *Rethinking Rural Poverty Reduction in Afghanistan*, 1.

198 Currently, the UN estimates that there are 40–50 drug labs in Badakhshan province, with each processing 1 ton of heroin a year; UNODC, *Opiate Flows Through Northern Afghanistan and Central Asia: A Threat Assessment* (UNODC, 2012), 10.

199 Starkey, Jerome, “How UK Junkie Cash Will Kill Our Boys,” last modified April 29, 2008, http://www.thesun.co.uk/sol/homepage/news/campaigns/our_boys/1101163/News-Our-Boys-Forces-How-UK-junkie-cash-will-kill-Our-Boys.html

programs more complex to manage. In effect, Badakhshan has had to create community programs that will be beneficial to both Afghan and Tajikistan addicts, since so many smugglers and migrants cross the border.

The fourth reason for weaker provincial drug treatment programs is corruption, which is amplified because of proximity to the border. As in the previous case studies, corruption decreases allocated funds to the poor and prohibits drug policies from being initiated. Even though government officials in Badakhshan and Tajikistan publicly state that they prefer to not partner with insurgent groups, there are some that are financially swayed by the huge profits.²⁰⁰ Tensions especially occur between government and the national border police when trying to carry out eradication and interdiction.²⁰¹ This resistance is mostly due to both sides blaming each other for not responding adequately to the smuggling networks. The friction is preventing both sides from tackling the issue in a collaborative manner. The indecisiveness of both countries has caused a drift between their citizens and justice systems. These bad perceptions have further increased border security problems within the region and made recruitment of the police force challenging. For example, low wages and high casualty rates make it difficult to convince residents to become policemen; those who are hired repeatedly fail to show up for work.²⁰²

Residents have begun to see police and justice system as illegitimate, because both have failed in enforcing offenses that include drug trafficking and corruption. Instead of using judicial courts, many have turned to a more local approach to solve disputes because it is less expense, timely, and more dependable. As an alternative, they request mediators, who are “elected members of provincial council... [and] are more familiar with local problems and the parties involved than judges and governors who are

200 “Unlike in southern Afghanistan, Taliban and other Anti-Government Elements (AGE) are apparently not taxing the opium trade with any regularity in northern Afghanistan. There are, however, specific locations in northern Afghanistan bordering Tajikistan where AGE appear to be partially funding their operations through the drug economy, and in turn protect it from interdiction;” UNODC, *Opiate Flows Through Northern Afghanistan*, 7.

201 Cole Hansen, Christian Dennys, and Idrees Zaman, *Conflict Analysis: Baharak District, Badakhshan Province* (Kabul: Cooperation for Peace and Unity, 2009), 8.

202 Max Planck Institute for Comparative Law and International Law, *Annex D: Support to Provincial Governance: Provincial Needs Assessment Badakhshan* (Heidelberg: Max Planck Institute for Comparative Law and International Law, 2009), 6.

appointed from Kabul.”²⁰³ Other residents have decided to turn to more informal groups, such as street leaders, to receive justice which is concerning because it could lead to more violence in the future.²⁰⁴ While the international community has put money towards interdiction efforts, they have struggled to respond quickly because global trafficking is so complex. Recently, Afghanistan, Russia, and U.S. agencies succeeded in destroying six heroin labs in Badakhshan province and confiscating “180 kg of heroin, 1,500 kg of morphine, and 1,200 kg of opium during the raids.”²⁰⁵ Stronger enforcement along with improving public support of government is crucial to instilling a more collaborative community approach when developing drug policies for citizens.

The last explanation for why Badakhshan is seen as the weakest of the three provinces is that it lacks network capability and recovery capital. Since Badakhshan is seen as relatively stable, when compared to other countries, it has received less monetary support from the international community. As a result, addiction programs are not prioritized, because there are other more life-threatening issues that must be addressed in Afghanistan. This frustrates residents, because they feel their good behavior is preventing them from getting the assistance they need. While the international community has tried to develop financial incentives for Badakhshan, they have been unsuccessful in reaching the entire population, which is large and impoverished. Donors have also struggled to collaborate closely with local government to build a community health network; this is mostly due to a lack of resources in the region.

Furthermore, there is no referral system to assist addicts which has increased inefficiencies. The rough terrain and poverty in the region has become a major hindrance in communications. While treatment may be free for addicts, many cannot afford the travel. Addicts in rural areas have even fewer social workers who could direct them to specialized welfare services. Drug treatment programs could be enriched by connecting

²⁰³ Max Planck Institute for Comparative Law and International Law, *Annex D: Support to Provincial Governance*, 7

²⁰⁴ Refworld, *How Will Badakhshan Recover from Violence?* (Washington, DC: Institute for War and Peace Reporting, 2012), 1.

²⁰⁵ “Heroin Labs harm Locals,” *Sada-e Azadi*, last modified September 28, 2012, <http://sada-e-azadi.net/Joomla/index.php/en/topics/features/6844-heroin-labs-harm-locals>

provincial education and health awareness campaigns. Collaboration could additionally be improved at the national level by expanding infrastructure (e.g., roads and technology) so that they could be more involved in the monitoring process.

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V. CONCLUDING POINTS

A. CONNECTING SOCIO-ECONOMIC MARKETS TO DRUG TREATMENT

This thesis has presented a structured, comparative assessment of drug treatment quality in three Afghan provinces along with detailed case studies contextualizing and explaining these outcomes on the basis of social, political, economic, and psychological factors. On this basis, this thesis has confirmed that there is a connection between the drug industry, poverty, and addiction. Clinical studies have found that the majority of addicts use drugs because of depression and unemployment.²⁰⁶ To prevent a drug addiction spiral from occurring, Afghanistan needs to start investing in its population. In short, Afghanistan residents desire hope in the future so that they do not have to turn to drugs to mask the pain. While providing social alternatives seems like a simple solution to the addiction problem, the provincial case studies found that it was an extremely difficult task to undertake.

The biggest challenge found in all the three case studies was corruption associated with the drug industry. Corruption has delegitimized local institutions and made it difficult for residents to trust provincial leaders, central government, and donor intentions. This has been particularly troubling in Kandahar province; where some tribal ties are still closely connected to the Taliban. Negative perceptions can be improved by increasing social welfare programs. While this takes time, the National Solidarity Program has already seen significant progress in using development to change perceptions.²⁰⁷ Success was also confirmed through the case studies—with the most influential provinces already having social networks in place prior to tackling drug addiction, along with programs that targeted individual well-being.

²⁰⁶ Stanekzai et al., “Baseline Assessment of Community Knowledge,” 451.

²⁰⁷ “We find that villagers residing in communities which have received projects are more likely to hold positive perceptions of their economic situation and exhibit positive attitudes towards the government”; Beath, Christia, and Enikolopov, “Winning Hearts and Minds Through Development,” 2.

Dealing with corruption at the national level is more challenging, because it requires collaboration with central government. All three of the case studies mentioned that weak law enforcement and the illicit drug industry prohibited treatment programs from being effective. In some cases, like the national alternative prison program, drug policies worsened the situation and made addicts further reliant on substances. An enhanced marketplace would deter some of the repercussions from eradication and interdiction methods and reduce the chance of residents returning back to the drug industry for support. More connections in civil society would additionally increase communication between sectors which is necessary to increase transparency at the national level.

Anti-corruption efforts could also be improved by creating a portal that holds essential data. After reviewing the case studies, it was apparent that reporting procedures were lacking and that data was inaccurate. Many of the reports had not been updated for two to three years on the MOPH website. Having a national technical information system that could connect health, welfare, and criminal justice sectors together would be extremely useful in enhancing transparency. A more advanced system would help donors understand provincial capacity as well as ensure that central government is participatory in monitoring and evaluation. Relationships would improve by an information system, because actors involved would understand each other's intentions.

The case studies additionally identified the need to improve human resources and administrative concerns within drug treatment programs. The section on clinical governance showed that there was a huge gap in expertise in the mental health field. Kabul is more advanced because it has more educated residents who are active in advocating for addicts and researching provincial needs. Since drug treatment is linked with unemployment, it is the ideal mechanism to advocate for improving human capital. When improving the workforce, provinces should seek counsel from tribal groups. In the case study research, they were seen as beneficial in standardizing procedures and informing residents of new programs. Since tribal networks have the same objective in decreasing addiction rates, they may have suggestions for making programs more culturally appropriate. This is important, because literacy is not prioritized in most clans.

In addition, they may have recommendations on how to enforce and incorporate governance policies into their tribal programs.

These case studies have reinforced the notion that targeting drug addiction along with simultaneously strengthening economic markets and enhancing opportunities for individuals is the best option to break the vicious drug cycle in Afghanistan. It is the best way to counteract warlords, because they cannot recruit drug traffickers and opium farmers when individuals are not vulnerable to socio-economic conditions. This method also highlights the importance of legitimizing institutions and assisting the poor, which is the main objective of intervening in Afghanistan. While there are numerous challenges that must be addressed, increased economic markets and social services has the potential to expand community networks and make central governance more accountable in its actions. This type of reconstruction can be done in a non-confrontational way, and requires a more participatory role from locals to complement donor assistance. Empowering locals to become active in their community is the best way through which to break addiction—if residents feel they have control to change their future, reform is more likely to happen.

B. MOVING FORWARD- HOW TO TACKLE THE DRUG TRADE THROUGH ADDICTION

Since Afghanistan is constantly changing in terms of stability, there should be an action plan when developing social services and economic markets. As shown in the case studies, each province needs an individual assessment to ensure the infrastructure set up is sustainable. The following questions should be considered when moving forward: Are socio-economic opportunities broad enough to combat the tightly aligned drug network? Is expanding these opportunities feasible? How would this affect the role of counter narcotics? Are there potential negative implications that could emerge from tackling the drug trade differently?

Expanding socio-economic opportunities is enough to fix the drug trade dilemma. As mentioned in the literature review, U.S.-led and UN-led counter narcotic strategies must be done concurrently to ensure regional stability. Corruption cannot be improved

and drug treatment policies cannot be implemented without stronger law enforcement. This was reinforced in the case studies as well as the report regarding negative attitudes towards government—social service projects were only effective in improving community perceptions in “regions with moderate levels of initial violence.”²⁰⁸ Moreover, the drug treatment, security/governance, and economic components can sometimes mask each other’s strengths and weaknesses, opening the possibility of creating a more integrated approach to development. Programs aimed at countering narcotics are necessary for the security and stability of a province; without such efforts, economic infrastructure cannot survive. Building socio-economic infrastructure will, in turn, begin to close the poverty gap, which is one of the repercussions of eradication and interdiction methods. Infrastructure investments will also promote collective action within the community, prioritize individual access to political and economic opportunities, and enhance attention by the central government.

While the integration of socio-economic and counter narcotic procedures is a better option than the status quo, some may wonder about feasibility. All three provinces studied here lacked the resources and capabilities necessary to developing infrastructure. This thesis also showed that Afghanistan’s health networks were completely dependent on foreign aid. While the international community has agreed to continue giving funds after troops deploy, it is unclear in how they are going to hand over responsibility to central government as time progresses. If central government does not take ownership and prioritize both the socio-economic and counter-narcotic dimensions of intervention, neither will be effective.

Although there are financial gaps that must be addressed; some of the concerns will be improved by connecting these two elements of a coordinated approach, so that information is transparent and systems are more efficient. In addition, stronger communication networks and improved clinical governance would ensure more accountability and participation from key players. Currently, funding is prioritized to high risk regions like Kabul, Kandahar, and Badakhshan. A few of the traits that define a

208 Beath, Christia, and Enikolopov, “Winning Hearts and Minds Through Development,” 2.

high risk province are proximity to the border, high population density, and involvement in the drug trafficking trade. If the two approaches are connected, they may be able to reach more at-risk regions. To understand how financial gaps would be addressed and how resources would be allocated in the future, further research needs to be done on donor expectations.

Lastly, there is concern that development would produce a domino effect, meaning that the drug trade would just transfer to a new location if it was unable to recruit the impoverished in the current locations. This is a concern, because the drug industry has relocated in the past. Yet drug treatment and counter narcotic programs should continue to be developed, because it is the international community's responsibility to protect citizens from insurgent groups as well as enforce illicit drug trafficking. While legalization is the other answer, it is currently impractical since the initiative would require global consensus.

The more problematic insight in regards to the domino effect came from the case studies, when there was a shift in opium cultivation in Badakhshan. Some residents saw involvement in the drug trade as a means to gather more donor funds. The global community does not want to incentivize bad behavior nor push a country to change its socio-economic structure without being fully equipped or willing to do so. If a province is unprepared, socio-economic developments could have the opposite effect and weaken efforts from the international community. The international community is aware of this backlash and has created programs to incentivize good behavior in more stable provinces. Simultaneously doing counter narcotic policies and socio-economic initiatives should alleviate some of these concerns. Stronger local relationships should prevent cases like these from happening; there would be a local outlet which residents could suggest such concerns.

While this is a different route towards tackling poverty, connecting past approaches and emphasizing drug addiction seems like the best option. Instead of re-inventing the wheel, scholars and regional experts can enrich methods that have already been implemented in the past. Psychological initiatives will need to be restructured to ensure that the strongest institutions are connected with the drug trafficking,

governance/security, and economic dimensions of intervention. Instead of putting more funds to new programs, these ideas suggest that development officers focus on efficiency and sustainability, with attention to monitoring and evaluation helping to produce better results. This thesis has represented one attempt to bring granular evidence to bear in drawing the links across the economic, sociopolitical, and psychological levels at play in building more successful drug treatment programs in Afghanistan.

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